

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #1c & 2c filed 11/29/67

15499

CERTIFICATE OF DEATH

15497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>61 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>18 Severndale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gloria</u> Middle <u>Blanche</u> Last <u>Elizabeth</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 March 1924</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George C. McAvoy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lamb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 15, 1967</u> , to <u>Nov. 18, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 18, 1967</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James J. Nordlund, M.D.</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		F.M. 22b. DATE SIGNED <u>Nov. 19, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>James J. Nordlund, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Seaside Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Palermo, N.J.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1948

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1948



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15488

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>DOA</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> d. STREET ADDRESS <u>4013 1/2 PLYERS MILL RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MELVIN</u> First Middle Last <u>ADDISON</u>		4. DATE OF DEATH Month Day Year <u>NOV</u> <u>18</u> <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/97</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT ADDISON</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>NIECE</u> <u>GLORIA HOPKINS - 4007 PLYERS MILL RD</u>		Address <u>Kensington, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, tuberculous</u> DUE TO (b) <u>Exacerbation of a chronic pulmonary tuberculosis</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L. Ball</u> EXAMINER'S NAME (Type)		22. DATE SIGNED <u>Nov-19-1967</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>MT. ZION, MONTG. MD.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

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7-1-77
[Faint text, possibly a date and a reference number]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15489

1. PLACE OF DEATH a. COUNTY Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1201 Forest Glen Road	
3. NAME OF DECEASED (Type or print) Harry First NMN Middle Ager Last		4. DATE OF DEATH Month November Day 12 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1919
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Ager		14. MOTHER'S MAIDEN NAME Kate	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 579-07-8485	
17. INFORMANT Sam Cohen		Address 4201 Cathedral Ave. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Underdetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED Nov. 12, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 13, 1967	23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR B. Baugant & Son		25a. REC'D BY REGISTRAR NOV 15 1967	
ADDRESS 3501-14th St N.W.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

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<div style="display: flex; justify-content: space-between;"> <div> <div>15500</div> <div> <div>4</div> <div>1</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>15500</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN 1b <u>2 years</u>						d. STREET ADDRESS <u>2528 B Holman Avenue</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2528 B Holman Avenue</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>Mae</u> Last <u>Albright</u>						4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 18, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ALTOONA Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel HOFFMAN</u>						14. MOTHER'S MAIDEN NAME <u>Sara DEVER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>170-38-5631</u>		17. INFORMANT <u>Margaret M. Streit</u>		Address <u>2528 B. Holman Ave. SS. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of the pancreas + Uterus ampulla</u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 months +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>September</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>September, 1967</u> , to <u>Nov. 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 13, 1967</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Hugo G. Graziani</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI</u>						22d. ADDRESS <u>10101 GEORGIA AVENUE, SILVER SP. MD.</u>		22b. DATE SIGNED <u>11/16/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NORTH SIDE CATHOLIC CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WESTVIEW TOWNSHIP, PITTSBURG PA.</u>			
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>						ADDRESS <u>2222 W. 1st Ave N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DATE <u>NOV 21 1967</u>					

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12508

15501

CERTIFICATE OF DEATH

15501

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural)		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE PLAINS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL			d. STREET ADDRESS RT#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLIS Middle A Last ALBRIGHT			4. DATE OF DEATH Month NOV. Day 14 Year 19 67		
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 SEPT. 1907	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. SERVICE USAF		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BERKELEY CO. W. VA.	
13. FATHER'S NAME WILLIAM ALBRIGHT			14. MOTHER'S MAIDEN NAME SERABELL ARMBRASTEN Sara Belle Armbraster		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 223 50 3505		17. INFORMANT RUBY C. ALBRIGHT Address RT#2 WHITE PLAINS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of the lung DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12 OCT. 1967 , to 14 NOV. 1967 , that (I) (we) last saw the deceased alive on Nov. 14 19 67 , and that death occurred at 615 P M , from causes and on the date stated above.					
22a. SIGNATURE C. S. Reeves			22b. DATE SIGNED 16 Nov. 1967		
22c. PHYSICIAN'S NAME (Type) C. S. REEVES, M. D.			22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-18-1967	23c. NAME OF CEMETERY OR CREMATORY ROSEDALE		23d. LOCATION (City or Town) (County) (State) MARTINSBURG W. VA.	
24. FUNERAL DIRECTOR BROWN FUNERAL HOME MARTINSBURG, W. VA.			25a. RECD BY REGISTRAR NOV 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15504

CERTIFICATE OF DEATH

15502

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4012 Franklin Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>A</u> First <u>LeRoy</u> Middle <u>Alderman</u> Last		4. DATE OF DEATH <u>November</u> Month <u>19</u> Day <u>1967</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26/1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive trucking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank E. Alderman</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Pitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-9565</u>	
17. INFORMANT <u>Mrs. Alderman - above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Ventricular fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary artery blood disease</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 to <u>1967</u> , that (II) (we) last saw the deceased alive on <u>Oct 10</u> 19 <u>67</u> , and that death occurred at <u>11:20</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard J. Walsh</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>		22d. ADDRESS <u>1800 Eye St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Milliken, Michigan</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12202

DEPT. OF AGR.

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Thompson

Thompson

Thompson

Kempster

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4015 South St.

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Wash. D.C.

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Chickadee - 1821

1821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15503

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>745 Monroe St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Helen Holt Alexander</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>30</i> Year <i>1967</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-18-20</i>		9. AGE (In years last birthday) <i>47</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Martin Holt</i>		14. MOTHER'S MAIDEN NAME <i>Crisie Rogers Holt</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Fred. Latney Lewis Home</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1944/1/1 Pulmonary edema, intra alveolar hemmorrhage</i> DUE TO (b) <i>Cardiac hypertrophy and dilatation</i> DUE TO (c) <i>Secondary anemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>Dec 1, 1967</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-9-67 Family Plot</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro, N.C.</i>		23d. LOCATION (City or town) (County) (State)			
24. FUNERAL DIRECTOR <i>Catany Funeral Home 3831 2nd Ave NW Wash. DC</i>		25a. REC'D BY REGISTRAR <i>DEC 6 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		25c. NAME OF CEMETERY OR CREMATORY		25d. LOCATION (City or town) (County) (State)		25e. DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12503

12503

The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 11th of the
 month of May, 1911.

The names of the persons who
 were present at the meeting
 held on the 11th of the
 month of May, 1911.

The names of the persons who
 were present at the meeting
 held on the 11th of the
 month of May, 1911.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15506					15504				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4601 Harling Lane					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4601 Harling Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle S. Last Allen			4. DATE OF DEATH Month Nov. Day 5, Year 19 67						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 15 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wooster, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Joseph G. Sanborn			14. MOTHER'S MAIDEN NAME Kate E. Day						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-2079		17. INFORMANT Son James H. Allen		Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC INTESTINAL OBSTRUCTION 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) CARCINOMA of COLON DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OSTEO POROSIS SEVERE						INTERVAL BETWEEN ONSET AND DEATH 2 YRS 2 YRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from OCT. 20, 1955 , to Nov. 5, 1967 , that (I) (we) last saw the deceased alive on OCT. 31, 1967 , and that death occurred at 6:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Robert G. Angle				22b. DATE SIGNED Nov. 5, 1967					
22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE				22d. ADDRESS 5009 Del Ray Ave. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-67		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION (City, town or county) (State) S. Fort Mitchell, Ky.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR NOV 9 1967 DATE 25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15507											
15505											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>					d. STREET ADDRESS <u>1806 6th St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lucy Allison</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1967</u>						
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/1884</u>		9. AGE (In years last birthday) <u>83</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Lawrens, S.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Charley Casey</u>					14. MOTHER'S MAIDEN NAME <u>Ella Glenn</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>381-10-1950</u>		17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Arteriosclerosis Sclerophle</u> 444x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/67</u> , 19 <u>67</u> , to <u>Nov. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/7/67</u> , and that death occurred at <u>4A</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Myron L. Leuker</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 18, 1967</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>			23d. LOCATION (City or Town) (County) (State) <u>Landover, Maryland</u>				
24. FUNERAL DIRECTOR <u>W. Ernest Jarvis Co., Inc.</u>					ADDRESS <u>Jarvis funeral home 1432 20th St N.W.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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PROBATE, W. A. A. A. A.

PROBATE, W. A. A. A. A.

PROBATE, W. A. A. A. A.

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PROBATE, W. A. A. A. A.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15508

CERTIFICATE OF DEATH

15506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>1513 Erskine Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Boghos Andonian</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-22-96</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Helper, Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.D.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Hagop Andonian</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Chulgian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>018-07-0625</u>		17. INFORMANT <u>Patient's chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Cholangitis</u> DUE TO (c) <u>Chronic cholecystitis & cholelithiasis + cholecholelithiasis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old pleurisy, recent cholecystectomy, pneumonia.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II of item 18.) <u>_____</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov 3</u> , 19 <u>67</u> , to <u>Nov 8</u> , 19 <u>67</u> , that (I) <u>(not)</u> saw the deceased alive on <u>Nov 7</u> , 19 <u>67</u> , and that death occurred at <u>5:30 A.</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>W.W. Eastman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.W. Eastman</u>				22d. ADDRESS <u>831 Univ. Blvd. East, Sil. Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, A.C.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc. 8655 Ga. Ave. Silver Spring, Md</u>				25a. REC'D BY REGISTRAR <u>DATE NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>	

12502

12502

RECORD OF DEATH

8

Chloroform
Chloroform
Chloroform

Chloroform
Chloroform
Chloroform

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b & c Film #G395 11/29/67 ph

15509

CERTIFICATE OF DEATH

15507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md</u>		d. STREET ADDRESS <u>Potomac Valley Club</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>M.</u> Last <u>ATHERTON, JR.</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-96</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper-Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iowa (Clinton)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa (Clinton)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Irak K. Atherton</u>		14. MOTHER'S MAIDEN NAME <u>Solia Hinton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>578-48-0699</u>	
17. INFORMANT <u>Harry M. Atherton, JR 11717 Enid Dr</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Pulmonary insufficiency</u> DUE TO (c) <u>Bilateral pneumonia, probably aspiration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sev. hours</u> <u>sev. days</u> <u>sev. days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, electrolyte imbalance, generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>Nov 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>67</u> , and that death occurred at <u>2:50</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. MITCHELL</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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1551

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[Faint, illegible handwriting covering the majority of the page]

15510

CERTIFICATE OF DEATH

15508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Discovered & Cleared with Host Co. Med. Examiner

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 13230 Bregman St.	
3. NAME OF DECEASED (Type or print) Rueben Lamar Baker		4. DATE OF DEATH Month 11 Day 18 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/86
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Tyson Baker		14. MOTHER'S MAIDEN NAME Edith Sullivan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214 03 9349	
17. INFORMANT Edith Keller		Address 12910 New Hampshire Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DISEASE DUE TO CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO GEN'L ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH YES YES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS - HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug, 1964 , to 11/18, 1967 , that (I) (we) last saw the deceased alive on 11/18, 1967 ; and that death occurred at 6:10 PM from causes and on the date stated above.			
22a. SIGNATURE Donald Lewis		22b. DATE SIGNED 11/19/67	
22c. PHYSICIAN'S NAME (Type) Donald Lewis MD.		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67	
23c. NAME OF CEMETERY OR CREMATORY Colesville Meth. Cem.		23d. LOCATION (City or Town) (County) (State) Colesville Montg. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler F. H.		25a. REC'D BY REGISTRAR NOV 24 1967	
ADDRESS 1331 Rockville Pike Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

15511

CERTIFICATE OF DEATH

15509

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 1409 Langley Way	
3. NAME OF DECEASED (Type or print) First Harry Middle none Last Barick		4. DATE OF DEATH Month 11 Day 9 Year 1967	
5. SEX male	6. COLOR OR RACE Caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1896
9. AGE (In years lost, birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 9 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rayfield Barick		14. MOTHER'S MAIDEN NAME Rebecca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 073-34-3958	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) 2 years			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basilar artery cerebral thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to 11-9, 1967 that (I) (we) last saw the deceased alive on 11-8-67 1967 and that death occurred at 10:00 M, from causes and on the date stated above.			
22a. SIGNATURE Jason Geiger		22b. DATE SIGNED 11-9-67	
22c. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		22d. ADDRESS 800 Pershing Dr., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-12-67	
23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Deans, N.J.	
24. FUNERAL DIRECTOR Geoffrey T. ...		25a. REC'D BY REGISTRAR NOV 10 1967	
25b. REGISTRAR'S SIGNATURE Charles ...			

90

Cleared: medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10228

10228



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15510

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 506 DENHAM ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL REID BARRETT II			4. DATE OF DEATH Month NOV. Day 12 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1967	9. AGE (In years lost birthday) yrs. 8 Months 6 Days 6 Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME MICHAEL REID BARRETT I			14. MOTHER'S MAIDEN NAME CHERYL MARDIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT MICHAEL REID BARRETT I FATHER Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and Atelectasis DUE TO (b) Viral Pneumonitis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) John G. Ball Bethesda, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/12/67 Address (Street, city, town, or county)		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY Rock. Pike		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Gadsden, Alabama	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR NOV 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01231

01231

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>				d. STREET ADDRESS <u>422 Lincoln ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Louis Baxter</u>				4. DATE OF DEATH <u>11 17 1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-13</u>	
				9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Defense Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Baxter</u>				14. MOTHER'S MAIDEN NAME <u>Larice</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. II 223 14 3794</u>		17. INFORMANT (WIFE) <u>Mrs Katherine M. Baxter (same as #2)</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>last.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>Nov. 18, 1967</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Jones</u> Address <u>274 Carroll St NW Washington DC</u> county					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Charles Jones</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

12012

12012

12012

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
CERTIFICATE OF DEATH					
15512					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital			d. STREET ADDRESS 6509 OLD STAGE RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle F. Last BECKMAN			4. DATE OF DEATH Month NOV. Day 7 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/77	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BARBER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WISCONSIN	
13. FATHER'S NAME CARL BECKMAN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 318-09-6930A		17. INFORMANT SON MORRIS - SAME Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 10/17 , 19 67 , to 11/7 , 19 67 , that (I) (we) last saw the deceased alive on 11/7 , 19 67 , and that death occurred at 11/7 M, from causes and on the date stated above.					
22a. SIGNATURE Ronald W. Barr			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Ronald W. Barr
22d. ADDRESS 10401 Old Georgetown Road, Bethesda, Md.			22e. REC'D BY REGISTRAR NOV 9 1967		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/11/67		
23c. NAME OF CEMETERY OR CREMATORY New Lisbon Cemetery			23d. LOCATION (City or Town) (County) (State) New Lisbon, Wisconsin		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home			25a. REGISTRAR'S SIGNATURE Charles J. J...		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15515

CERTIFICATE OF DEATH

15513

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY PR. GEO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bethesda		c. LENGTH OF STAY IN Tb 15 Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 16-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 6223 Fernwood Terrace	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Randall Leland Kirp Bereano		4. DATE OF DEATH Month November Day 9 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 November 1967
9. AGE (In years lost birthday) yrs. 15		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Philip L. Bereano		14. MOTHER'S MAIDEN NAME Nancy Dee Kirp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. None	
17. INFORMANT Philip L. Bereano, Riverdale, Maryland		18. ADDRESS 6223 Fernwood Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7620 IMMEDIATE CAUSE (a) Atelectasis, Lungs, Etiology Unknown DUE TO (b) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ----- INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6:31am, 9 Nov, 1967 , to 9:30PM, 9 Nov 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9 November 1967 , and that death occurred at 9:30PM , from causes and on the date stated above.			
22a. SIGNATURE G. P. Swartz		22b. DATE SIGNED 11 November 1967	
22c. PHYSICIAN'S NAME (Type) G. P. Swartz		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-12-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery	23d. LOCATION (City or Town) (County) (State) Woodbridge, New Jersey
24. FUNERAL DIRECTOR Goldberg Funeral Home, Washington, D.C.		25a. REC'D BY REGISTRAR DATE NOV 13 1967	25b. REGISTRAR'S SIGNATURE O'Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15516			
15514			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>7 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>255 Troy Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Bern</u> Last <u>Bern</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/98</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Menosha Bernstein</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Schwartz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	
17. INFORMANT <u>Mr. Ellis Berne</u>		Address <u>9209 Whitney Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial artery thrombosis & myocardial infarction</u> DUE TO (b) <u>infarction</u> DUE TO (c) <u>Congestive failure (pulmonary oedema)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerotic cardiovascular disease</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/4/67</u> , 19 <u>67</u> , to <u>11/14/67</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>14 Nov</u> 19 <u>67</u> , and that death occurred at <u>8:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Khamon M.D.</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Khamon M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd Silver Spring MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth David Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Long Island, New York</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		ADDRESS <u>232 Carroll Wash DC 20012</u>	
25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15517

CERTIFICATE OF DEATH

15515

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Hialeah</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hialeah</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>948 West 79th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Richard</u> Last <u>BERRIOS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1947</u>
9. AGE (In years last birthday) yrs. <u>19</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marine Corps</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ralph Berrios</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Inez M. Malgrat</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give year or dates of service) <u>Yes 1966-1967</u>		16. SOCIAL SECURITY NO. <u>267 80 9453</u>	
17. INFORMANT <u>Hialeah, Florida</u> <u>Mr. John Ralph Berrios, 948 West 79th St.</u>		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>991X</u> IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> DUE TO (b) <u>Multiple gunshot wounds to abdomen</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Rifle shots received Da Nang, South Viet Nam</u>	
20c. TIME OF INJURY Month, Day, Year <u>300</u> Hour <u>a.m.</u> <u>26 Aug 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>30 miles south Da Nang</u>		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>Sept. 20</u> , 19 <u>67</u> , to <u>Nov. 27</u> , 19 <u>67</u> , that (if (we) last saw the deceased alive on <u>Nov. 27</u> , 19 <u>67</u> , and that death occurred at <u>420A M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.R. Hix</u>		22b. DATE SIGNED <u>Nov. 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.R. HIX M.D.</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Vista Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Hialeah, Florida</u>	
24. FUNERAL DIRECTOR <u>Falls Church Funeral Home</u> <u>1102 West Broad Street, Falls Church, Va.</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS	

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REMARKS OF ORIGIN

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

15519												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												15516											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN 1b <u>22 years</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8000 Blair Mill Road</u>												d. STREET ADDRESS <u>8000 Blair Mill Road</u>																							
3. NAME OF DECEASED (Type or print) First <u>Myra</u> Middle <u>E</u> Last <u>Black</u>												4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 67</u>																							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1897</u>				9. AGE (In years last birthday) yrs. <u>70</u>				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS. Hours Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Asst. Exec. Sec. Trans-World Air.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>						11. BIRTHPLACE (State or foreign country) <u>USA</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																	
13. FATHER'S NAME <u>Aaron Black</u>						14. MOTHER'S MAIDEN NAME <u>Collins</u>																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-03-6970</u>				17. INFORMANT <u>8000 Blair Mill Rd.</u> <u>Mrs. Frances H. Jabant-Silver Spring, Md.</u>																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED <u>Nov. 27, 1967</u>																							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						ADDRESS (City or town) (County) (State) <u>Washington</u>						23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Nov. 29, 1967</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>						23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>					
General Director <u>Thomas H. Harkins</u> 8434 Georgia Ave. <u>Warner E. Pumphrey, Inc.</u> Silver Spring, Md.												25d. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>												25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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FOR THE EXAMINER - SPECIAL AGENT

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CERTIFICATE OF DEATH

15517

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN.		d. STREET ADDRESS 8210-N. Hamp. Ave.	
3. NAME OF DECEASED (Type or print) Rose First Middle Last Blumenthal		4. DATE OF DEATH Month November Day 23 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-20-1889
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADOLPH MANN		14. MOTHER'S MAIDEN NAME ELIZABETH (UNK.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-10-1957D	
17. INFORMANT MAURICE H. WARSAW		Address (same as 2a)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 BRONCHOPNEUMONIA DUE TO (b) arteriosclerotic heart disease DUE TO (c) with implanted pacemaker			INTERVAL BETWEEN ONSET AND DEATH 2 days years 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 1967, to Nov 23 , 1967, that (I) (we) last saw the deceased alive on Nov 22 , 1967, and that death occurred at 7:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Sydney Leventhal		22b. DATE SIGNED Nov 23, 1967	
22c. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/26/67	23c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL Cem.	23d. LOCATION (City or town) (County) (State) OXON HILL, MD.
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME		25a. REC'D BY REGISTRAR 4217-9th St. NW.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by Dr. Sydney Leventhal

12519

RECEIVED OF 12519

12517

12519

Blackwell

15520

CERTIFICATE OF DEATH

15518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>169 Elm Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Milton</u> First <u>Bollman</u> Middle <u>Bollman</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	9. AGE (In years last birthday) yrs. <u>80</u>
11. BIRTHPLACE (County & State, or foreign country) <u>OAKLAND, CALIFORNIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>CALVIN P. BOLLMAN</u>		14. MOTHER'S MAIDEN NAME <u>PITILENA ROBINSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578 46 5499</u>	
17. INFORMANT <u>ARTHUR W. BOLLMAN</u> Address <u>(SAME AS #2)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-17, 1967</u> , to <u>11-20, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-20, 1967</u> , and that death occurred at <u>6:34 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R.C. Kirchner</u>		22b. DATE SIGNED <u>11-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER M.D.</u>		22d. ADDRESS <u>6480 N. H. AVE. - TAKOMA PARK, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 24-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington</u>	23d. LOCATION (City or town) (County) (State) <u>Large Rd. & Geo. Md</u>
24. FUNERAL DIRECTOR <u>Arthur Watters Washington, D.C. 20012</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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81331

RECEIVED

81331

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15521

CERTIFICATE OF DEATH

15519

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	
c. LENGTH OF STAY IN 1b <u>33 hours</u>		d. STREET ADDRESS <u>6435 Burke Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>F</u> Last <u>Boase</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/07</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Henry Boase</u>		14. MOTHER'S MARDEN NAME <u>Margaret King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-1581</u>	
17. INFORMANT <u>Wife - Freda - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>67</u> , to <u>present</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>11/28</u> 19 <u>67</u> , and that death occurred at <u>11p</u> M, from causes on and the date stated above.			
22a. SIGNATURE <u>John B. Umhau M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/29/67</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHOU MD</u>		22d. ADDRESS <u>8805 Conn. Ave. Chevy Chase, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01251

01251

12-2-51
188-1-2-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Items 18 & 19		396 1-2-68		MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
15522		CERTIFICATE OF DEATH		15520	
1. PLACE OF DEATH a. COUNTY <u>MONT.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>5901 Spaatz Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HIRAM A. BUCHER</u>		4. DATE OF DEATH <u>11 9 1967</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreign Service Dept. of State</u>		9. AGE (In years lost birthday) <u>70 yrs.</u>		10. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u>	
11. FATHER'S NAME <u>Unknown</u>		12. MOTHER'S MAIDEN NAME <u>Unknown</u>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>	
14. SOCIAL SECURITY NO. <u>220-44-0421</u>		15. INFORMANT <u>Valerie Boucher</u>		16. 30 Platsburg Court, N.W. Washington, D. C. Rm. 309	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490 X</u> DUE TO (b) <u>Bilateral pulmonary pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Emphysema</u>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
26. (City or town) (County) (State) <u></u>		27. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1958</u> to <u>11-9 1967</u> that (I) (we) lost saw the deceased alive on <u>11/8 1967</u> and that death occurred at <u>6:55 AM</u> from causes and on the date stated above.		28. SIGNATURE <u>Barton J. Gershen</u>	
29. PHYSICIAN'S NAME (Type) <u>Barton J. Gershen</u>		30. ATTENDING PHYS. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		31. DATE SIGNED <u>11/9/67</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>Nov. 11, 1967</u>		34. NAME OF CEMETERY OR CREMATORY <u>Kock Creek Cemetery</u>	
35. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		36. REC'D BY REGISTRAR <u>NOV 15 1967</u>		37. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13230

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Delayed & cleared by Dr. B. Reap

VR A15 (4)
25M 1/67

15521

15523

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 9305 Long Branch Pkwy.	
3. NAME OF DECEASED (Type or print) James (none) Brothwell		4. DATE OF DEATH Month November Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/77
9. AGE (In years last birthday) 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (County & State, or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Brothwell	
14. MOTHER'S MAIDEN NAME Elizabeth Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 038-22-2505		17. INFORMANT Daughter, Address Marion Bower 9305 Long Br. Pkwy. S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 62 , to Nov 17 , 19 67 , that (I) (we) lost saw the deceased alive on Nov 12 , 19 67 , and that death occurred at 7:15 PM , from causes and on the date stated above.			
22a. SIGNATURE A. F. Thibadeau		22b. DATE SIGNED 11/17/67	
22c. PHYSICIAN'S NAME (Type) A.F. THIBADEAU		22d. ADDRESS Silver Spring, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 11-21-67	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Bladensburg Md.
24. FUNERAL DIRECTOR W.W. Chambers 640 Silver Spring Md		25a. REC'D BY REGISTRAR Nov 20 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

18821

18822

RECEIVED

APR 12

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U.S. DEPARTMENT OF AGRICULTURE

CERTIFICATE OF DEATH

15524

15522

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>7 weeks</u>		d. STREET ADDRESS <u>611 Silver Spring Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan Gay Buell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/43</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>C. E. Render</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Alden W. Buell</u>		18. ADDRESS <u>611 Silver Spring Avenue Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>456X</u> <u>Uremic Syndrome + Pseudomonas Pyelonephritis</u> DUE TO (b) <u>Lupus Nephritis - Malignant Hypertension</u> DUE TO (c) <u>Systemic Lupus Erythematosus</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 months - days</u> <u>2 years - 3 months</u> <u>8-10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>November 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov - 2</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Hubert G. Graziani</u>		22b. DATE SIGNED <u>11/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUBERT G. GRAZIANI, M.D.</u>		22d. ADDRESS <u>1101 GEORGIA AVE, S.S. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10222

STATE OF TEXAS

10222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15525

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15523

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN lb <u>23 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> 15-1 d. STREET ADDRESS <u>9205 EAST PARK HILL DR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL R. Bullock</u>			4. DATE OF DEATH Month Day Year <u>Nov 20 1967</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/09</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>	
13. FATHER'S NAME <u>WILLIAM H. BULLOCK</u>			14. MOTHER'S MAIDEN NAME <u>MOLLY Mc DANIEL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MARY Bullock - WIFE - SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT CACHEXIA, due to</u> <u>LIPOSARCOMA, RETRO PERITONEAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LIPOSARCOMA, RETRO PERITONEAL</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>6 MONTH</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>SEPT 7, 1954</u> , to <u>NOV. 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 20, 1967</u> , and that death occurred at <u>12:05 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Robert G. Angle</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>NOV. 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>			22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

13522

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13524

Robert J. White

3000 E. 1st Ave.
Chicago, Illinois

11-22-37 Mr. Lennard G. ...
11-22-37 Mr. Lennard G. ...

11-22-37 Mr. Lennard G. ...
11-22-37 Mr. Lennard G. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15525					15524					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Montgomery</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		a. STATE <i>Maryland</i>			b. COUNTY <i>Montgomery</i>		
			c. LENGTH OF STAY IN 1b <i>30 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1574 East West Highway</i>					d. STREET ADDRESS <i>1574 East West Highway</i>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last <i>Mary Bertha Burke</i>					Month Day Year <i>November 9 1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Cauc</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 14, 1896</i>		9. AGE (In years last birthday) <i>70</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive-Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Newfoundland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Martin Burke</i>					14. MOTHER'S MAIDEN NAME <i>Nora Murphy</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>001-09-6101 A</i>					
17. INFORMANT <i>Mrs. Francis E. Mc Ardle</i>					Address <i>1574 East West Highway Silver Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Essential Hypertension</i> DUE TO (c)								<i>one day</i> <i>5 yrs</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>August 1948</i> to <i>11/8</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> 19 <i>67</i> , and that death occurred at <i>12</i> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <i>William T. Saccardi</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/11/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>William T. Saccardi</i>						22d. ADDRESS <i>1150 Conn. Ave N.W. WASH. D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Rural</i>			23b. DATE THEREOF <i>Nov. 14, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Rosindale, Mass.</i>		
24. FUNERAL DIRECTOR <i>John Thomas</i> <i>Warner E. Pumphrey, Inc.</i>					ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 15 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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15525

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 MONTHS + ROAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOYD'S</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				d. STREET ADDRESS <u> Hwy #1 121 BOX 19</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BURCHYL S. BURNETTE</u>				4. DATE OF DEATH Month Day Year <u>Nov 18 1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/05</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHILTON CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. BURNETTE</u>				14. MOTHER'S MAIDEN NAME <u>NANCY SHARLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>067-10-8953</u>		17. INFORMANT <u>EVELYN BURNETT - WIFE</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANOXIA-POSTOP. COMPLICATIONS-RESECTION LUNG</u> (c) <u>BRONCHIAL CARCINOMA (POSTOPERATIVE)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>6 MOS. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG.</u> , 1967, to <u>NOV. 18</u> , 1967, that (I) (we) last saw the deceased alive on <u>NOV 18</u> , 1967, and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>J. H. Peabody Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH W. PEABODY JR. M.D.</u>				22d. ADDRESS <u>1234 19th St. N.W. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Akron Ohio</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>				25a. REC'D BY REGISTRAR <u>1331 Rockville Address Pike</u> <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15528

CERTIFICATE OF DEATH

15526

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		d. STREET ADDRESS <u>315 Leighton Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Riggs Bussard</u>		4. DATE OF DEATH <u>November 19 19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-10</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. C. Transit</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Manakee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-95-2783</u>	
17. INFORMANT <u>Earl C. Bussard</u>		Address <u>315 Leighton Avenue Hospital chart Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 355X IMMEDIATE CAUSE (a) <u>terminal multiple neurological complications</u> DUE TO (b) <u>leukellian degeneration</u> DUE TO (c) <u>leukellian degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1967</u> , to <u>Nov 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1967</u> , and that death occurred at <u>6:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hugh Gray</u>		22b. DATE SIGNED <u>11/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hugh Gray</u>		22d. ADDRESS <u>11161 New Hampshire Ave., Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR <u>Barner & Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 22 1967</u>			

1952

CERTIFICATE OF DEATH

1952

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 18, Film #395		MARYLAND STATE DEPARTMENT OF HEALTH	
12-12-67		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
15522		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 4701 Saul Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Timothy Middle Oberem Last Callagy		4. DATE OF DEATH Month November Day 24 Year 19 67	
5. SEX Male		6. COLOR OR RACE Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1967	
9. AGE (In years lost birthday) yrs. 7 Months 11 Days 11 Hours 11 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David W. CALLAGY		14. MOTHER'S MAIDEN NAME Joan Mary Oberem	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT David W. Callagy, Father, 4701 Saul Road, Kensington, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3400 MENINGOENCEPHALITIS - H. Influenzae DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 85 MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 NOV , 19 67 , to Nov. 24 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 24 , 19 67 , and that death occurred at 10:35 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 25 NOV 1967	
22c. PHYSICIAN'S NAME (Type) LT G.P. SWARTZ, MC, USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/27/67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Rockville, Maryland		25a. REC'D BY REGISTRAR NOV 28 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11, 12, 13 & 14, Form #3396 12/20/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15528

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Gea</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene Calloway</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-46</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Calloway</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Mays</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination (Hemothorax)</u> DUE TO (b) <u>due to gunshot wound in</u> DUE TO (c) <u>Chest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, Item 18.) <u>Deceased shot in chest during altercation in yard.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:50 P.M. 11-8-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, for business, street, office bldg., etc.) <u>Yard</u>		20f. (City or town) <u>Hyattsville, Prince Md</u> (State) <u>Prince Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-12-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, Ga.</u>	
24. FUNERAL DIRECTOR <u>Washington Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>11/8/67</u>	

Examination (New York)

Examination (New York)

Examination (New York)

Examination (New York)

Examination (New York)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15531		15529	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spring Field	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 5224 Kepler Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MONA VIVIAN CAPPARELL		4. DATE OF DEATH November 2 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/12
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Passport Div, State Dept.		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E.J. Armstrong		14. MOTHER'S MAIDEN NAME Mary Worden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Thomas Capparell-husband		Address (Add. same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8035 IMMEDIATE CAUSE (a) Fat embolism, pulmonary and cerebral DUE TO Multiple fractures and lacerations Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) Automobile Accident		INTERVAL BETWEEN ONSET AND DEATH 11 days 12 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran off highway hitting utility pole	
20c. TIME OF INJURY Month, Day, Year 7:25 p.m. 10/22 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) (County) (State) Bethesda Montgomery Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Ball		22. DATE SIGNED 11/2/67	
EXAMINER'S NAME (Type) John H. Ball		22. DATE SIGNED 11/2/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 Nov 1967	
23c. NAME OF CEMETERY OR CREMATORY Stewartsville Cemetery		23d. LOCATION (City or Town) (County) (State) Stewartsville, Mo.	
24. FUNERAL DIRECTOR Ives Funeral Home, Inc. Arlington, Va.		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/57

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>15-1</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>					d. STREET ADDRESS <u>1110 Ruppert Rd.</u>						
3. NAME OF DECEASED (Type or print) <u>Arthur Elliott Carleton</u>					4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1967</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-87</u>		9. AGE (In years last birthday) <u>80</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>			11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>John Carleton</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>577-01-9228</u>		17. INFORMANT <u>Dorothy Sheppard</u> Address <u>1110 Ruppert Rd. Silver Spring, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Acute bronchopneumonia associated</u> DUE TO (b) <u>with acute and chronic pyelonephritis</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>				22. DATE SIGNED <u>Nov. 26, 1967</u>							
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <u>Charles J. Jones</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>				
24. FUNERAL DIRECTOR <u>Warner C. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15533		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15531	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: <u>Reform School, Gaithersburg</u>) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>10 days / 23 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>			e. STREET ADDRESS <u>52 W Deer Park Dr PK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Edith</u> Middle <u>Carter</u> Last			4. DATE OF DEATH <u>November 20</u> 19 <u>67</u> Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1893</u>		9. AGE (In years <u>74</u> yrs.)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John HOWES</u>			14. MOTHER'S MAIDEN NAME <u>Helen Marie Gaither</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-9155</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave PK</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Cardiovascular disease</u> (b) <u>Chronic Renal Insufficiency</u> (c) <u>Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Renal Insufficiency</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9 Nov</u> 19 <u>67</u> to <u>20 Nov</u> 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>30 Nov</u> 19 <u>67</u> and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas P. Fogarty</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>21 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty MD</u>		22d. ADDRESS <u>1011 University Blvd E, Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	
23d. LOCATION (City or Town) <u>Gaithersburg</u> (County) <u>Montgomery</u> (State) <u>Md.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey Inc.</u> 8434 Georgia Avenue S.E. Md.			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 28 1967</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY MONTGOM.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS 9008 FAIRVIEW RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 9008 FAIRVIEW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES P. CASBARIAN		4. DATE OF DEATH Nov. 25 1967	
5. SEX M	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/1900
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chairman of Board & President Southern Md. Bank & Trust Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Boghus G. Casbarian		14. MOTHER'S MAIDEN NAME Carrie L. Wilfong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harvey T. Casbarian Sherwood Forest, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Nov. 25, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11/28/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company ADDRESS 2001 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR NOV 29 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15535

CERTIFICATE OF DEATH

15533

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle L. Last CHARLES		4. DATE OF DEATH Month November Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1888
9. AGE (In years lost birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lowell		14. MOTHER'S MAIDEN NAME Alice Canty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-10-1960	
17. INFORMANT Mary Mc Carthy, Friend, Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO 10 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1942 , 19 _____ to 11-5 , 19 67 , that I lost saw the deceased alive on 11-4 , 19 67 , and that death occurred at 7:40 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 1st NW, WASH. D.C. 20006 DATE SIGNED 11-5-67 ACTUAL SIGNATURE James J. Burns M.D. PHYSICIAN'S NAME (Type) JAMES T. BURNS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/67	
22c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Washington, D.C. 20016		24a. REC'D BY REGISTRAR NOV 9 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15536

15534

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u> </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAROMA PARK</u>				c. LENGTH OF STAY IN It <u>5 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp.</u>				e. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) <u>HELEN, SERENA CHRISTIANSON</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH <u>2-6-'07</u>	9. AGE (In years lost birthday) yrs. <u>60</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>	
13. FATHER'S NAME <u>GEORGE W. BROWN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>MARY RUTH MANN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>481343851</u>				17. INFORMANT (<u>BROTHER</u>) <u>Joseph W. BROWN</u> Address <u>1720 Blair Mill Road, Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute INTRA CEREBRAL Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>			
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20e. (City or town) <u> </u>				20f. (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/29, 1967</u> , to <u>11/2, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/1 1967</u> , and that death occurred at <u>7:30 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u>				22b. DATE SIGNED <u>NOV 2 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u>				22d. ADDRESS <u>7733 ALASKA AVENUE NW WASHINGTON D.C. 20012</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ONEWA CITY Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>ONEWA, IOWA</u>	
24. FUNERAL DIRECTOR <u>W W Chambers Co Inc</u>				25. REC'D BY REGISTRAR <u>11/6/67</u>			
25a. ADDRESS <u>Washington</u>				25b. REGISTRAR'S SIGNATURE <u>John J. ...</u>			

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CERTIFICATE OF DEATH

15535

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS 101 WEBSTER ST. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle CLAYMAN Last		4. DATE OF DEATH Month 11 Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1909 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HYMAN BRODSKY		14. MOTHER'S MAIDEN NAME GILDA BARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS. SONIA FISHERMAN		Address 5115-10TH, AVE WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid Arthritis - Severe			INTERVAL BETWEEN ONSET AND DEATH Acute
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May, 1966 to 2 November 1967 that (I) (we) last saw the deceased alive on 3 November 1967, and that death occurred at 6:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Jack Crowell		22b. DATE SIGNED 3 November '67	
22c. PHYSICIAN'S NAME (Type) JACK CROWELL		22d. ADDRESS 2025 EYE ST., N.W. Washington DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/5/67	23c. NAME OF CEMETERY OR CREMATORY ADAMS ISRAEL CEM.	23d. LOCATION (City or Town) (County) (State) WASH. D.C.
24. FUNERAL DIRECTOR Soleley Funeral Home 4217 9th St NW		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15532 CERTIFICATE OF DEATH 15536									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>					d. STREET ADDRESS <u>15415 Rowland Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Millicent Clements</u>					4. DATE OF DEATH Month Day Year <u>11/26 19 67</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28/1895</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Eugene Douglas Cabel</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Mead</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-44-6712</u>		17. INFORMANT <u>Stanley J. Clements</u> ^{Address} <u>15415 Rowland Lane Silver Spring, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac arrest</u> DUE TO (b) <u>metastatic ovarian adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ 1750								INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>over 1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>Nov. 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov. 24</u> , 1967, and that death occurred at <u>4:45 PM</u> , from causes on and on the date stated above.									
22a. SIGNATURE <u>W H Clements</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 26, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>William Clements, M.D.</u>					22d. ADDRESS <u>6001 35th Ave., Hyattsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>		
24a. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
155339											
15537											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>2 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>15708 Ancient Oak Dr</u>					
3. NAME OF DECEASED (Type or print) <u>William Conrad Clever</u>						4. DATE OF DEATH <u>11 12 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/20/1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR <u>12</u> Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>W. H. CLEVER</u>						14. MOTHER'S MAIDEN NAME <u>MOLLIE WESTAFER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>CORA A. CLEVER - SISTER - SAME</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Few days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Lymphoblastic Lymphosarcoma</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>67</u> , to <u>11/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> P.M., from causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Pollen</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>						22d. ADDRESS <u>1040 CONNECTICUT AVE, KENSINGTON MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u> ADDRESS <u>3004 EOTNE</u>						25a. REC'D BY REGISTRAR <u>NOV 16 1967</u> OATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1853

RECEIVED

1853

Received of Mr. J. B. Smith
the sum of \$100.00
for the purchase of land
in the town of Smith
County, Mo. 10/10/53

Witness my hand and seal
this 10th day of October
1853.

J. B. Smith
County Clerk

1
M
26
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15540

CERTIFICATE OF DEATH

15538

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
13 Days		Springfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
U.S. Naval Hospital, Bethesda, Maryland		7200 Dormont St.	
3. NAME OF DECEASED (Type or print) Lindsey H. COE		4. DATE OF DEATH November 25 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 SEP 1958
9. AGE (In years lost birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Honolulu, Hawaii	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		U.S.A.	
13. FATHER'S NAME George B. COE		14. MOTHER'S MAIDEN NAME Virginia HARRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA	
17. INFORMANT George B. COE		Address Springfield 7200 Dormont St., VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2044 LEUKEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH TWO YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 NOV , 1967, to 25 NOV , 1967, that (I) (we) last saw the deceased alive on 25 NOV 1967, and that death occurred at 8:45AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 25 NOV 1967	
22c. PHYSICIAN'S NAME (Type) Lt G.P. SWARTZ, MC, USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/26/67	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) ATHENS, TENN.	
24. FUNERAL DIRECTOR Robert E. Wilhelm		25a. REC'D BY REGISTRAR NOV 30 1967	
ADDRESS 4308 Suitland Rd. WDC		25b. REGISTRAR'S SIGNATURE [Signature]	

35271

0250

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15541

Item #2b,c & d Film #394 11/10/67 kk

15539

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN tb 14 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adolphus Middle Elmore Last Coffee		4. DATE OF DEATH Month Nov. Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-80
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKN		14. MOTHER'S MAIDEN NAME UNKN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Montgomery General Hospital Olney, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, L.L. bil. DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO Generalized arteriosclerosis (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, urethral stricture, rabies			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 , that (I) (we) last saw the deceased alive on 11-2 19 67 , and that death occurred at 3:50 am from causes and on the date stated above.			
22a. SIGNATURE John R. Spencer		22b. DATE SIGNED 11-2-67	
22c. PHYSICIAN'S NAME (Type) Dr. John R. Spencer		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/4/67	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR NOV 7 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge			

12333

12333



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15548

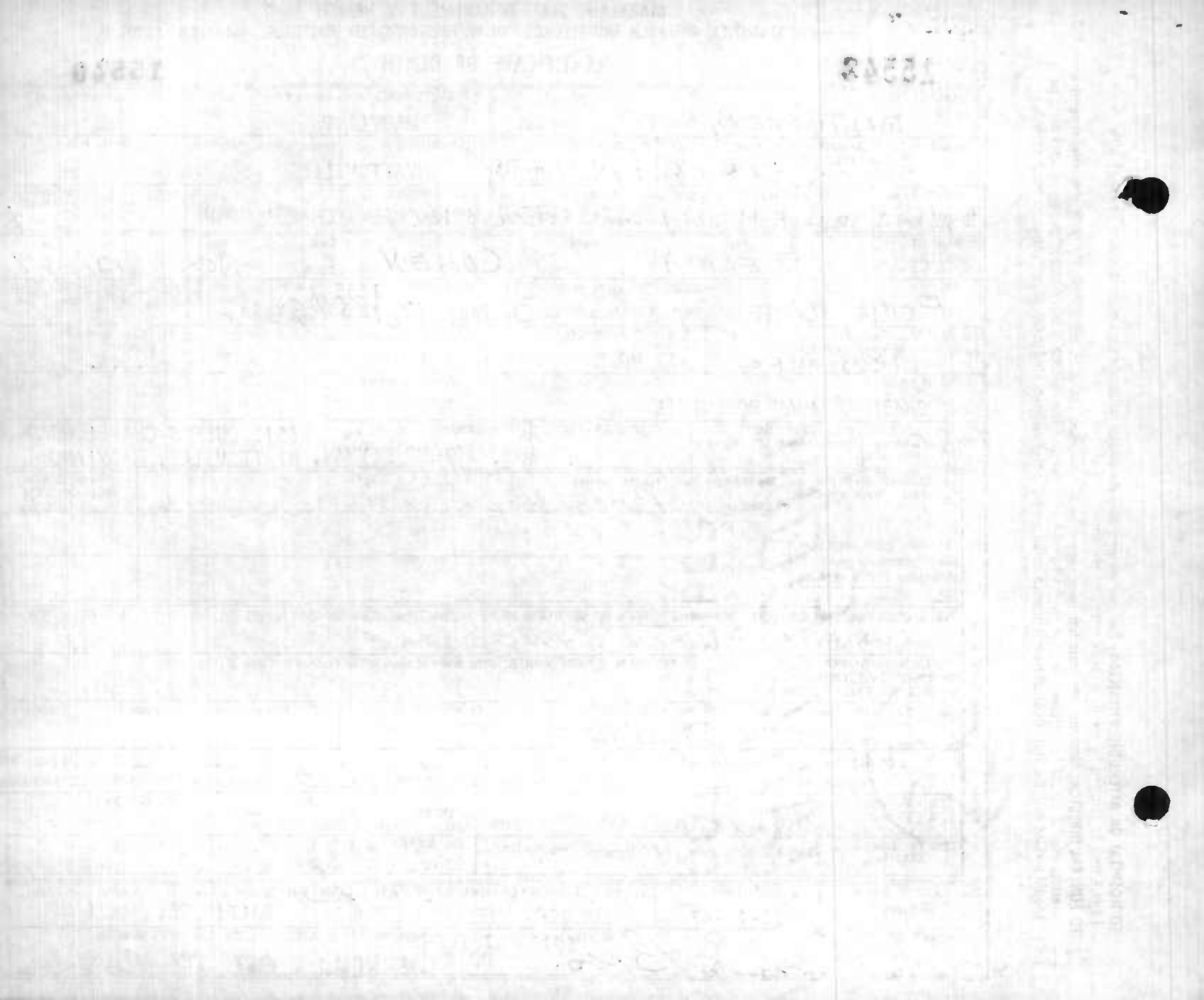
CERTIFICATE OF DEATH

15540

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR GEN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 yr. 4 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN MANOR HEALTH CARE CENTER		d. STREET ADDRESS 6512 QUEENS CHAPEL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ZELMA First Middle Last COHEN		4. DATE OF DEATH Nov. 12 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 Mar. 18, 1883 9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) LUTHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHAIM ABRAHAM ROSENTHAL		14. MOTHER'S MAIDEN NAME RENA ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ARTHUR WEYMAN, 6512 QUEENS CHAPEL ROAD, HYATTSVILLE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-14- , 19 67 , to 11-12- , 19 67 that (I) (we) last saw the deceased alive on 11-9- , 19 67 , and that death occurred at 12:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Samuel A. Hillman		22b. DATE SIGNED 11-12-67	
22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN		22d. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD-20901	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-13-67	
23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Ed. Lewinson Bros.		25a. REC'D BY REGISTRAR 6010 REISTERS TOWN ROAD DATE NOV 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

12345

12345



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH																								
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																								
CERTIFICATE OF DEATH																								
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home					d. STREET ADDRESS 7800 Fulbright Ct.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First E. Middle Warren Last Colison					4. DATE OF DEATH Month 11 Day 14 Year 1967																			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-09		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive					10b. KIND OF BUSINESS OR INDUSTRY Dept., Store					11. BIRTHPLACE (State or foreign country) D.C.					12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME George S. Colison					14. MOTHER'S MAIDEN NAME Eva Carter																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 577-01-4857					17. INFORMANT Lois Colison (wife)					Address Bethesda, Md. 7800 Fulbright Ct.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor - astrocytoma 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 5 months														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from September, 1967 , to Nov. 14, 1967 , that (I) (we) last saw the deceased alive on Nov. 13, 1967 , and that death occurred at 12:25 AM from the causes and on the date stated above.										22a. SIGNATURE Karl F. Wieneke, M.D.					22b. DATE SIGNED 11/14/67									
22c. PHYSICIAN'S NAME (Type) Karl F. Wieneke, M. D.					22d. ADDRESS Georgetown University Hospital																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-16-1967					23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery					23d. LOCATION (City, town, or county) (State) Rockville, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Jas. Gawler's Sons, Inc.										ADDRESS Washington, D.C.					25a. REC'D BY REGISTRAR NOV 17 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				

18546

CERTIFICATE OF DEATH

18546

Name of Deceased		Date of Death	
George B. Johnson		July 10, 1900	
Age		35 years	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Soldier	
Cause of Death		Typhoid Fever	
Place of Death		Home	
Signature of Physician		J. H. Smith	
Signature of Registrar		J. H. Smith	
Date of Registration		July 10, 1900	
Place of Registration		City of New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEOR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b —	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSP.		d. STREET ADDRESS 3200 CHILLUM ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last COLLIERE		4. DATE OF DEATH Month 11 Day 26 Year 19 67	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/03
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY R.R. INSPECTOR	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 918-14-9908	
17. INFORMANT MRS PHILOMENA COLLIERE - SAME #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Lung + Bowel DUE TO (b) 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lactory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 65 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on Nov 25 , 19 67 , and that death occurred at 12 Noon , from causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 11-26-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIV. BLVD E, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR J. Wm. Lees Sons, 300 4th St. NE, Wash. DC		25a. REC'D BY REGISTRAR NOV 30 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Judge			

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15543 CERTIFICATE OF DEATH 15543

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN ID 26 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 619 University Blvd. East		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 619 University Blvd. East e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEATRICE O. COLVIN		4. DATE OF DEATH Nov. 30, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1909
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles W. Burton		14. MOTHER'S MAIDEN NAME Sarah E. Burton Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Stuart E. Colvin	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, colon, primary (c) Carcinoma, colon, primary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1967 , to Nov. 30, 1967 , that (I) (we) last saw the deceased alive on Oct. 28, 1967 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A.W. Smith		22b. DATE SIGNED 11-30-67	
22c. PHYSICIAN'S NAME (Type) A.W. SMITH		22d. ADDRESS 13018 GEORGIA AVE WHEATON, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-2-67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 4 1967 25b. REGISTRAR'S SIGNATURE J. J. Judge	

15543

15543

[Faint, mostly illegible text covering the main body of the page, possibly a list or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tarboard papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 7 1/2 MONTHS		d. STREET ADDRESS 5060 Bradley Boulevard	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURS. HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. CONAHAN Last 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		4. DATE OF DEATH Month 11 Day 14 Year 1967	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-73
9. AGE (In years lost birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
11b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) STOCKTON, PA	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Daniel Conahan	
14. MOTHER'S MAIDEN NAME Lovena Siklekler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 577-03-99974		17. INFORMANT Joseph Connor Address 5100 Dorset Ave. Chevy Chase, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA- RESPIRATORY ARREST 18 MINS. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHO PNEUMONIA DUE TO (c) CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PLEURAL EFFUSION; ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY , 1966, to NOV. 14 , 1967, that (I) (we) last saw the deceased alive on Nov. 13 , 1967, and that death occurred at 12:55AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph I. Connor		22b. DATE SIGNED Nov. 14, 1967	
22c. PHYSICIAN'S NAME (Type) JOSEPH I. CONNOR		22d. ADDRESS 9420 Old Georgetown Rd. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-17-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15547			
CERTIFICATE OF DEATH			
15545			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>1511</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>910 Copley Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Robert Conger</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1907</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Bruce Conger</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Marie Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mother - as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1</u> DUE TO <u>1</u> (c) <u>1</u> DUE TO <u>1</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. J. Jones</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Marvin Monte</u>		22d. ADDRESS <u>1003 Spring St SE, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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EXTRACT OF DATA

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CERTIFICATE OF DEATH

15546

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>910 Copley Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Ruth Conger</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) yrs. <u>—</u> IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>18</u> Min. <u>57</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>David Bruce Conger</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Marie Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father (chart)</u> Address <u>as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO (b) <u>776x</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/28/67-5pm</u> , 19 <u>67</u> , to <u>11/28/67pm</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8pm 11/28</u> , 19 <u>67</u> , and that death occurred at <u>9:29p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Holliver</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Holliver</u>		22d. ADDRESS <u>Holy Cross Hospt-Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>	
26. ADDRESS <u>Funeral Home-1331 Rockville Pike</u>		DATE <u>DEC 6 1967</u>	
Rockville, Md.			

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15549

CERTIFICATE OF DEATH

15547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beallsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beallsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>FULTON</u> Middle <u>COOLEY</u> Last		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 19 1980</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Own Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachariah Cooley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. George Bodmer</u> Address <u>Beallsville Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular disease</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year. Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1950</u> to <u>NOV 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 14 1967</u> , and that death occurred at <u>1 P. M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Sawcett</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg. Md</u>
24. FUNERAL DIRECTOR <u>Constance C. Hilton</u> ADDRESS <u>Barnesville Md</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15550 CERTIFICATE OF DEATH 15548									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4242 East-West Highway					d. STREET ADDRESS 4242 East-West Highway			15-1	
3. NAME OF DECEASED (Type or print) First ELSPETH Middle BROOKS Last MONTGOMERY COOPER					4. DATE OF DEATH Month Nov. Day 26, Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1914		9. AGE (in years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) International Consultant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Warren Montgomery					14. MOTHER'S MAIDEN NAME Florence Cary				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-46-2167		17. INFORMANT Husband Harold Cooper		Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL AZOTEMIA 592x DUE TO CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 40 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from JAN. 1, 1957 to NOV. 26, 1967 , that (I) (we) last saw the deceased alive on NOV. 25, 1967 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Robert G. Angle					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 26, 1967		
22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE					22d. ADDRESS 5009 Del Ray Ave. Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11-27-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

422

22321

$$\text{CH}_3\text{COO}^- \rightleftharpoons \text{CH}_3\text{COOH}$$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Cooper Mrs. Nellie

Item 18 Film 395 12-1-67		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
15551		15549	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Charleston</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charleston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>111</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>J.</u> Middle <u>Cooper</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lemuel Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Effie Gillespie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-72-3243</u>	
17. INFORMANT <u>Ruth Bsharah-Charleston, West Va.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation (arteriosclerotic heart disease)</u> DUE TO (b) <u>Bilateral lobular pneumonia</u> DUE TO (c) <u>Lytic lesions of skull, petrous part of temporal bone</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoporosis, severe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 18, 1967</u> , to <u>November 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 20, 1967</u> , and that death occurred at <u>8 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		22b. DATE SIGNED <u>November 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr.</u>		22d. ADDRESS <u>9301 Galesville Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>11/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Memorial Park Cem. London, West Va</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 24 1967</u>	

15551

REPORT ON TRAIN

15551

15551-15551

15552

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15550

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 7027 Strathmore Street	
3. NAME OF DECEASED (Type or print) EDITH B. COWELL		4. DATE OF DEATH Month Nov. 1, Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1888
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Baird		14. MOTHER'S MAIDEN NAME Jane Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Son Baird E. Cowell		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Generalized Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/30 , 19 67 , to 10-31- , 19 67 , that (I) (we) last saw the deceased alive on 10/31 , 19 67 , and that death occurred at 3A M, from causes and on the date stated above.			
22a. SIGNATURE W. T. JOYCE		22b. DATE SIGNED 11-1-67	
22c. PHYSICIAN'S NAME (Type) W. T. JOYCE		22d. ADDRESS 4977 Battery Lane Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-3-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 3 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1922

RECORD OF DEATH

1922

Montgomery

Barling

Montgomery

Green Glass

30 days

Green Glass

7027 Baltimore Street

Green Glass

Green Glass

Green Glass

Nov. 22, 1888 78

Nov. 22, 1888 78

Barling

Green Glass

Jan. 1889

Green Glass

Barling

Nov. 22, 1888 78

Nov. 22, 1888 78

1922

1922

Barling, Montgomery

Barling, Montgomery

Barling, Montgomery

Barling, Montgomery

Barling, Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15553

CERTIFICATE OF DEATH

15551

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>6 mos 25 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47-3		d. STREET ADDRESS <u>2333 Skyland Pl. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Lorena Cowgill</u>		4. DATE OF DEATH <u>November 10 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Not Known</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Not Known) Turner</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give wor or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>None</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding peptic ulcer</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>10/9 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4/10</u>		20f. (City or town) (County) (State) <u>4/10 1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/9 1967</u> to <u>4/10 1967</u> that (I) (we) last saw the deceased alive on <u>4/10 1967</u> , and that death occurred at <u>9 P.M.</u> from causes and on the date stated above.		22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>		22b. DATE SIGNED <u>11/10/67</u>	
22d. ADDRESS <u>2852 16 St NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Broad Fording Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St. NE, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

1922

RECORDS OF THE

1922

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15554

CERTIFICATE OF DEATH

15552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK	
c. LENGTH OF STAY IN 1b 1 mo		d. STREET ADDRESS 103 46th St. N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORA Middle M. Last COX		4. DATE OF DEATH Month NOV. Day 9 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1886
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME MAKER	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES F. BRILL		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT (SON) Address BETHESDA, MD		18. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		20. SOCIAL SECURITY NO. NONE	
21. I certify that (I) (this hospital) attended the deceased from 5/27/67 , 19 67 , to 11/10 , 19 67 , that (I) (we) last saw the deceased alive on 11/10 , 19 67 , and that death occurred at 12:45 AM , from causes and on the date stated above.		22. SIGNATURE William Brainin M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11/10/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 11-12-67	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR J. WM LEE & SONS ADDRESS 300 4th St. N.E., WASHINGTON, D.C.		25. REC'D BY REGISTRAR DATE NOV 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. DATE SIGNED 11/10/67	

12821

2533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15555

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15553

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Parks</u> c. LENGTH OF STAY IN 1b <u>2 days/2 1/2 hr</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN Edward COYLE</u>		4. DATE OF DEATH <u>NOVEMBER 15, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-27</u>
9. AGE (In years and birthday) <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John COYLE</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes W/W2</u>		16. SOCIAL SECURITY NO. <u>577-32-548</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>At death</u> <u>Two Days</u> <u>Several Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1967</u> , to <u>November 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 13, 1967</u> , and that death occurred at <u>1:35</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>11-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>11/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem. Baltimore, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>The H.H. Hine Co 2901 14th St. NW</u>		25a. REC'D BY REGISTRAR <u>Nov 16 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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15556

CERTIFICATE OF DEATH

17184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>16 DAYS</u>		d. STREET ADDRESS <u>1704 Black Oak Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>Eva</u> Middle <u>Craft</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER - Retired Co. Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX John A. Werle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eliz. XXXXXX Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-38-3980 A</u>	
17. INFORMANT <u>Robert H. Craft</u>		Address <u>220 Beaumont Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, HCVF & ASHD</u> DUE TO (b) <u>Arteriolar nephrosclerosis</u> DUE TO (c) <u>Thrombosis of left subclavian artery</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug, 1963</u> to <u>11-30, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-29-1967</u> , and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. H. Sengstack M.D.</u>		22b. DATE SIGNED <u>12-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Sengstack</u>		22d. ADDRESS <u>9241 Columbia Blvd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas & Son, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14184

CERTIFICATE OF BIRTH

1922

2422 Spring
Hwy 1200
May

Female White
Teacher

New York

born at New York, N.Y.

born at New York, N.Y.

born at New York, N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15557

CERTIFICATE OF DEATH

15554

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia d. STREET ADDRESS 3533 Porter St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM RAYMOND CRAMPTON First Middle Last		4. DATE OF DEATH NOVEMBER 10 19 67 Month Day Year				
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28 1891	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y		10b. KIND OF BUSINESS OR INDUSTRY Randolph and West		11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Wm. Crampton			14. MOTHER'S MAIDEN NAME Mary West			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-01-1295		17. INFORMANT Wm. G. Crampton, 11122 Stephelee Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO (b) Respiratory Failure DUE TO (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. For Advanced Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 3 years 5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 62 , to 11/10 , 19 67 , that (I) (was) last saw the deceased alive on 11/8 , 19 67 , and that death occurred at 8:00 A.M. from causes and on the date stated above.						
22a. SIGNATURE Frank Y. Jaggers Jr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/10/67		
22c. PHYSICIAN'S NAME (Type) FRANK Y JAGGERS JR		22d. ADDRESS 5707 WISCONSIN AVE				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Prince Geo. Co., Md.		
24. FUNERAL DIRECTOR Jos Gawler's Sons 5130 Wisconsin Av., NW.		ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR DATE NOV 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 yrs. 11 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle HAWK Last CREIGHTON		4. DATE OF DEATH Month Nov. Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1880
9. AGE (In years last birthday) yrs. 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) Easton, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Forman Hawk		14. MOTHER'S MAIDEN NAME Mary Jane Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-60-4473	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4330 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrest DUE TO (c) Heart Block		INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 min 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 50 , to 11/15 , 19 67 , that (I) (we) last saw the deceased alive on 10/15 , 19 67 , and that death occurred at 6:45 P.M., from causes and on the date stated above.			
22a. SIGNATURE Frank G. Jagers Jr		22b. DATE SIGNED 11-16-67	
22c. PHYSICIAN'S NAME (Type) FRANK JAGGERS JR		22d. ADDRESS 5707 Wisconsin Ave. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 11-18-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20a-20f film #395 12-12-67 mt		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		15556	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 11477 Columbia Pike Bl			
3. NAME OF DECEASED (Type or print) Crosby, Wayne Richard				4. DATE OF DEATH Month 16 , Nov, 67 Day 19 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/40	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months 2 Days 7	IF UNDER 24 HRS. Hours 15 Min. 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Bunker-Ramo Corp.		11. BIRTHPLACE (State or foreign country) Smithville Plats, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Crosby				14. MOTHER'S MAIDEN NAME Beatrice Armentrout			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes U.S.A.F.		16. SOCIAL SECURITY NO. 061-32-1723		17. INFORMANT Address Beatrice Crosby (Mother) Greene, N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 823.4 IMMEDIATE CAUSE (a) Multiple Extreme Injuries DUE TO (b) including fractured skull DUE TO (c) incurred in auto accident.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased lost control of Auto hitting bridge support					
20c. TIME OF INJURY Month, Day, Year 10:35 Hour 11 16 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Silver Spring Mont Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED Nov. 17, 1967
ACTUAL SIGNATURE Belden R. Reap		M.D. BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP		Address (City or town, county) Washington, D.C.		23d. LOCATION (City or Town) (County) (State) Greene, New York			
23a. BURIAL, CREMATION, REMAINS Burial		23b. DATE THEREOF 11/20/67		23c. NAME OF CEMETERY OR CREMATORY Sylvan Lawn		23d. LOCATION (City or Town) (County) (State) Greene, New York	
24. FUNERAL DIRECTOR W.W. Chambers, Co. Inc.				ADDRESS 517 11th Street S.E.		25a. REC'D BY REGISTRAR DATE NOV 20 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form R-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (P)
6M 1/67

15560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17185

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Schubert</i>			d. STREET ADDRESS <i>7807 Starke Rd</i>		
3. NAME OF DECEASED (Type or print) <i>John Paul - Crowley</i>			4. DATE OF DEATH <i>November 29 1967</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 26-1917</i>		9. AGE (In years last birthday) <i>50</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Supermarket Corp.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington - D.C.</i>	
13. FATHER'S NAME <i>John G. Crowley</i>			14. MOTHER'S MAIDEN NAME <i>Catherine Casey</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes 1941-1945</i>		16. SOCIAL SECURITY NO. <i>578-09-4237</i>		17. INFORMANT <i>Mrs. Crowley - Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive intracerebral hemorrhage, left, spontaneous</i> DUE TO (b) <i>Hypertensive cardio-vascular disease</i> DUE TO (c) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cirrhosis of liver, Laennec's type Wt 3000 grams</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D.		22. DATE SIGNED <i>11/30/67</i>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		Address (Street, city, town, or county) <i>Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-4-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
				23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>DEC 7 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15561

CERTIFICATE OF DEATH

15557

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DC - - - b. COUNTY - - -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home				d. STREET ADDRESS 4016 14th St. N.W. Kensington, Md.			
3. NAME OF DECEASED (Type or print) First ROSE Middle M. Last CULLEN				4. DATE OF DEATH Month Nov. Day 21 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1882	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Maryland		
13. FATHER'S NAME Ferdinand E. Burch			14. MOTHER'S MAIDEN NAME Sophronia Guy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-9722		17. INFORMANT Amma King Handwerk-8302 Woodhaven Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 491X						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic pulmonary fibrosis Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) arteriosclerosis					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-17-65 , to 11-21-67 , that (I) (we) last saw the deceased alive on 11-21-67 , and that death occurred at 5P M, from causes and on the date stated above.							
22a. SIGNATURE C P Ryland		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-21-67			
22c. PHYSICIAN'S NAME (Type) C P RYLAND		22d. ADDRESS 4800-49 St NW Wash DC 20016					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wash. D.C.				25a. REC'D BY REGISTRAR NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2255

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15562		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15558	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3722 Manor Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NINA First Maynard Middle Curtis Last		4. DATE OF DEATH Nov 21 1967 Month Nov Day 21 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-25-1875		9. AGE (In years last birthday) yrs. 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Hutchinson Martin		14. MOTHER'S MAIDEN NAME Nancy Jane Kinch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Mrs. Nina Brumbaugh- See Item No. 2 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April , 19 66 to Nov 21 , 19 67 , that (I) (we) last saw the deceased alive on Nov 13 , 19 67 , and that death occurred at 6:55 AM, from causes and on the date stated above.					
22a. SIGNATURE Wm Fleet Luckett M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11. 21 67	
22c. PHYSICIAN'S NAME (Type) Wm Fleet Luckett		22d. ADDRESS 5000 Pennsylvania			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-24-1967		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave. NW. Wash. D.C.		25a. REC'D BY REGISTRAR DATE NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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15563
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
15559

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		
c. LENGTH OF STAY in b. <u>12 days</u>		d. STREET ADDRESS <u>7911 Greenwood Avenue</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u> <u>Jakoma Park, Maryland</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Phoebe M. Davis</u>		4. DATE OF DEATH <u>November 25 1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 19, 1895</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John H. Ditzler</u>		14. MOTHER'S MAIDEN NAME <u>Frances Vernon</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>YES</u>		
17. INFORMANT <u>Mrs. Dorothy Williams</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>liver failure</u> <u>1530</u> DUE TO <u>Acute hepatic necrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>metastatic carcinoma</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u> <u>weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stress ulceration stomach; Carcinoma colon</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>67</u> to <u>11/25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>67</u> , and that death occurred at <u>9⁰⁰</u> M, from the causes and on the date stated above.				
22a. SIGNATURE <u>Norman H. Isaacson</u> M.D.		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. ISAACSON MD</u>		22d. ADDRESS <u>915 - 19th St NW Wash DC</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>DEC 1 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1953

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DEC 1 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15566

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15560

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>	
c. LENGTH OF STAY IN 1b <u>"1067 to '18"</u>		d. STREET ADDRESS <u>3507 Kensington Crt.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Reuben B. Dean</u>		4. DATE OF DEATH <u>11 18 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-84</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Kensington, Md.</u>		18. ADDRESS <u>Aubrey Dean-3507-Kensington Ct.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Embolus</u> DUE TO (b) <u>Bilateral Lobular Pneumonia</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 5, 1967</u> , to <u>NOV. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>NOV. 18, 1967</u> , and that death occurred at <u>12 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>11/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dean Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Green County, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc. 8434 Ga. Avenue</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15561

15565

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-15-68. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb Greenbelt	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp.		d. STREET ADDRESS 7010 Greenbelt Rd.	
3. NAME OF DECEASED (Type or print) First Amy Middle Viola Last Dent		4. DATE OF DEATH Month 11 Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 12 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Josiah Lindsay		14. MOTHER'S M maiden NAME Rosanna Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-28-6735	
17. INFORMANT Mary E. Brown-803 Seeks Lane, Silver Spring Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to acute coronary DUE TO (b) insufficiency; DUE TO (c) Coronary artery heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		22. DATE SIGNED Nov. 27, 1967	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town, county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/67	23c. NAME OF CEMETERY OR CREMATORY George Washington	23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Address Rockville, Md.		25a. REC'D BY REGISTRAR DEC 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

15502

15502

Handwritten notes and sketches, including a large circular diagram with internal lines and labels, and several smaller diagrams and text fragments.

15566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bedford</u>		c. LENGTH OF STAY IN fb <u>4 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>908 Bedford St</u>	
3. NAME OF DECEASED (Type or print) <u>Lena</u> First Middle Last		4. DATE OF DEATH <u>Nov 14</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1885</u> 82 yrs.
9. AGE (In years last birthday) <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Bedford Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Leasure</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hardin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter - Edith Taylor</u>		Address <u>5324 Phoenix Rd. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Cardio Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/14/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV. 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ZION MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>CUMBERLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>BYRON KIGHT</u>		25. REG. BY REGISTRAR <u>NOV 16 1967</u>	
ADDRESS <u>CUMBERLAND, MD.</u>		25. REG. BY REGISTRAR <u>NOV 16 1967</u>	

13223

13223



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15567		15563	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Va.</u> b. COUNTY <u>Cekington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cekington</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>3189 So. Stafford St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beonislawa DeWzalska</u>		4. DATE OF DEATH <u>11-30</u> 19 <u>67</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Gr</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-21-1891</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u> ✓	
13. FATHER'S NAME <u>Roman Tomoeski</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George DeWzalski - same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Blot dyscrasia of unknown origin</u> DUE TO (c) <u>Extensive infection of extensive</u> <u>Barian</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-27-</u> , 19 <u>65</u> , to <u>11-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-29-</u> , 19 <u>67</u> , and that death occurred at <u>10AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Richman</u> M.D.		22b. DATE SIGNED <u>12-1-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>4740 N. El. Ave. Ch. Ph. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-4-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	
ADDRESS <u>2222 Wis. Ave N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 915 MAPLE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN FRANK DONAHAE					4. DATE OF DEATH Month NOVEMBER Day 25 Year 19 67				
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 NOVEMBER 14 53		9. AGE (In years last birthday) yrs. 15.1 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) ENGLEWOOD, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FLORIN DONAHAE					14. MOTHER'S MAIDEN NAME ELIZABETH MULLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. 577 40 0954		17. INFORMANT Address Edna L. Donahae - wife- same item " 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 NOV , 19 67 , to 25 NOV , 19 67 , that (I) (we) last saw the deceased alive on 25 NOV , 19 67 , and that death occurred at 1:15AM , from causes and on the date stated above.									
22a. SIGNATURE C.S. Reeves						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 25 NOV 1967	
22c. PHYSICIAN'S NAME (Type) LT C.S. REEVES, MC, USN						22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR TYSON WHEELER,						25a. REC'D BY REGISTRAR NOV 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15569

CERTIFICATE OF DEATH

15565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN It		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>				d. STREET ADDRESS <u>1500 E.W. Highway</u>			
3. NAME OF DECEASED (Type or print) <u>Joan Marie Donaldson</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/67</u>	9. AGE (In years lost birthday) yrs. <u>14</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Craig Donaldson</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Seoller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>husband (via chart)</u> Address <u>(as above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 7605 DUE TO <u>a. Pulmonary hyaline membrane dis.</u> (b) <u>- Subarachnoid hemorrhage</u> DUE TO <u>(c) - Intraventricular hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/7/67</u> , 19 <u>67</u> , to <u>11/7/67</u> , that (I) (we) last saw the deceased alive on <u>11/7/67</u> , 19 <u>67</u> , and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stanley H. Steinberg</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley H. Steinberg</u>				22d. ADDRESS <u>1040 University Blvd, Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 Rock Pike</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

4022

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15566

1. PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 - North Street.</u>		d. STREET ADDRESS <u>100 N. Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Hershey</u> Middle Last		4. DATE OF DEATH <u>Nov.</u> Month <u>22</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1886</u> 81 yrs.
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Vail</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia & Carbon Monoxide poisoning, accidental</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stove explosion and gas suffocation</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>92 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gas oven exploded when trying to light it. Caused burns & shock</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>Nov. 20 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Rockville Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>Nov. 28, 1967</u>	
EXAMINER'S NAME (Type)		22b. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Mont. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	
ADDRESS <u>Rockville, Md.</u>		DATE <u>DEC 6 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15571

CERTIFICATE OF DEATH

15567

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>9039 SLIGO CREEK PKWY</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE</u> First <u>XXXXX</u> Middle <u>XXXXX</u> Last <u>DORTMAN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/11</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CENTERVILLE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MENDEL NICKEL</u>		14. MOTHER'S MAIDEN NAME <u>ROSE PUSHKIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-6535</u>	
17. INFORMANT <u>MR. JOSEPH S. DOREMAN</u>		Address <u>9039 SLIGO CREEK PKWY, PARKSIDE PLAZA APTS. SILVER SPRING</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>Nov 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>67</u> , and that death occurred at <u>7:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/20/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. [Signature]</u>		22d. ADDRESS <u>8641 Columbia Rd Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WORKMENS CIRCLE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15572

15568

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>10-10-67 to 11-15-67</u>		d. STREET ADDRESS <u>3352 Cheswick Court Apt 3G</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Young</u> Last <u>DRAKE</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-96</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tecumseh, Neb</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>ELMER E. Young</u>		14. MOTHER'S MAIDEN NAME <u>MOLLY CASTRO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>11-16-2766A</u>	
17. INFORMANT <u>ROBERT J. DRAKE</u>		Address <u>SAME AS - #2A-B-C-D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>July</u>		20f. (City or town) (County) (State) <u>Nov 1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 5</u> , 19 <u>67</u> , and that death occurred at <u>1:30 PM</u> from causes and on the date stated above.		22a. SIGNATURE <u>Richard A. Yates MD</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>		22b. DATE SIGNED <u>11/15/67</u>	
22d. ADDRESS <u>OLNEY, Md</u>		22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/18/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WYUKA Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>LINCOLN, NEBRASKA</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS INC. - SILVER SPRING, Md</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

12008

WALL OF DEATH

12013

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15573

15569

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4614 West Virginia Ave.</u>		d. STREET ADDRESS <u>4614 West Virginia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Albert Young Dreisonstok</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative officer-Navy Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Dreisonstok</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Leah Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Richard Dreisonstok-Rd. Silver Spring Md.</u>		Address <u>706 Forest Glen</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201 IMMEDIATE CAUSE (a) Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/1, 1967</u> , to <u>11/30, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/14, 1967</u> , and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr Joseph P. Kenrick</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/30/67</u>
22c. PHYSICIAN'S NAME (Type) <u>DR JOSEPH P. KENRICK</u>		22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem. Baltimore, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>		25c. ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	

13573

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

Items 18, 21 film #395 MARYLAND STATE DEPARTMENT OF HEALTH
12-6-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15576

Item #1c Film #3306 12/21/67 mt

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15570

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 1 DAY 1 1/2 Hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS Box 276 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Ray Dresser First Middle Last		4. DATE OF DEATH 11 26 19 67 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/05 9. AGE (In years lost birthday) yrs. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Dresse r		14. MOTHER'S MAIDEN NAME Janie Lanham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-05-0861 17. INFORMANT Medical Records of Montg. General Hospt. Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 4201 DUE TO (b) left anterior ventricular wall; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Coronary Artery Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap M.D.		22. DATE SIGNED Nov. 26, 1967 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Home, city, town, county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-29-67	23c. NAME OF CEMETERY OR CREMATORY Burtonsville	23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland
24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
15573				
CERTIFICATE OF DEATH				
15571				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON</u>		
c. LENGTH OF STAY IN 1b <u>28 days.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Route # 2</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First Middle Last		4. DATE OF DEATH <u>11-7</u> Day Month Year <u>1967</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-19</u> 48 yrs.		
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Richard Prather</u>		14. MOTHER'S MARDEN NAME <u>Bertha Prather</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Adenocarcinoma, left breast</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.				
22a. SIGNATURE <u>Stanley M. Bialer</u>		22b. DATE SIGNED <u>11-7-67</u>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		25a. REC'D BY REGISTRAR <u>Rockville</u>		
25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>		DATE <u>NOV 16 1967</u>		

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CERTIFICATE OF DEATH

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15572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN lb <i>3 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>915 Kennedy St. N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Martha Washington</i> First Middle Last <i>Early</i>		4. DATE OF DEATH Month Day Year <i>Nov. 21 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-22-12</i>
9. AGE (In years last birthday) <i>55 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>55</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Waitress</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter Poston</i>		14. MOTHER'S MAIDEN NAME <i>Edith Stickles</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-12-8193</i>	
17. INFORMANT <i>W.S.H. Hospital Records</i>		Address <i>Park, Ind. Takoma Park, Ind.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia & Exacerbated + High Blood Pressure</i> DUE TO (b) <i>Ac Myocardial Infarction</i> DUE TO (c) <i>He had previous arrhythmia & went into fibrillation during the attack</i> 4331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>4 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/21/67</i> , 19 <i>67</i> , to <i>11/21/67</i> , that (I) (we) last saw the deceased alive on <i>11/21/67</i> , and that death occurred at <i>1:30</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Chas H Wolotton</i> M.D.		22b. DATE SIGNED <i>11/21/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Chas H Wolotton</i>		22d. ADDRESS <i>831 Univ Blvd E. Silver Spring</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/25/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>NOV 27 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

12535

RECORDS OF DEATH

12535

15577

CERTIFICATE OF DEATH

15573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY in 1b 32 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Illinois b. COUNTY Glendale Heights c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 449 Altgeld Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Donald Last ELLIS		4. DATE OF DEATH Month November Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1947
9. AGE (In years lost birthday) yrs. 20		10. IF UNDER 1 YEAR Months Days Hours Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Haleyville, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Paul Ellis		14. MOTHER'S MAIDEN NAME Naomi Cummings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Aug 64-Nov 67		16. SOCIAL SECURITY NO. 336 40 5773	
17. INFORMANT Mrs. Naomi Moore, 449 Altgeld Avenue		18. ADDRESS Glendale Heights, Maryland Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7543 IMMEDIATE CAUSE (a) Congenital heart disease; atrial septal defect DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Oct. 13, 1967 , to Nov. 14, 1967 that (s) (we) last saw the deceased alive on Nov. 14, 1967 , and that death occurred at 105A M. from causes and on the date stated above.			
22a. SIGNATURE Perry Ah-Tye, M. D.		22b. DATE SIGNED Nov. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Perry Ah-Tye, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 11/15/67	23c. NAME OF CEMETERY OR CREMATORY Falls Church Funeral Home	23d. LOCATION (City or Town) (County) (State) Chicago, Illinois
24. FUNERAL DIRECTOR 1102 West Broad Street, Falls Church, Va.		25a. REC'D BY REGISTRAR NOV 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

522

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>519 Kerwin Rd.</u>							
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Naylor</u> Last <u>Estep</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-93</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin N. Estep</u>						14. MOTHER'S MAIDEN NAME <u>Eliz. A. Acton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-07-0231-A</u>		17. INFORMANT <u>Etta J. Estep</u>		Address <u>519 Kerwin Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Nov. 20, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Catholic Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brownstown, Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 24 1967</u>											

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2 Silver Spring

2 P. Kerning Rd

Holy Cross Hosp.

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United States
Department of
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and Welfare
Washington, D.C.

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15579

CERTIFICATE OF DEATH

15575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>802 Bowie Rd-</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>F</u> Last <u>FAHEY</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHEELDEX CORP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Allegany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael P. Fahey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McEann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Army</u>		16. SOCIAL SECURITY NO. <u>719-16-3802</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTERCAPILLARY GLOMERULOSCLEROSIS (Kimmelstiel)</u> DUE TO (c) <u>DIABETES MELLITUS (Long-standing)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>some years</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 19, 1967</u> to <u>Nov. 20, 1967</u> , that (1) (we) last saw the deceased alive on <u>Nov. 19, 1967</u> , and that death occurred at <u>5 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u>		22b. DATE SIGNED <u>Nov. 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. BOWDITCH HUNTER, JR.</u>		22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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OF THE STATE

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INTERNAL SECURITY (COMMUNIST)

INTERNAL SECURITY (COMMUNIST)

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANGLEY PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN., & HOSPITAL		d. STREET ADDRESS 8024 14TH. AVE	
3. NAME OF DECEASED (Type or print) ISADORE (NMN) FEINSTEIN		4. DATE OF DEATH Month 11 Day 1 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/14
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN STATE FURNITURE	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MAX FEINSTEIN		14. MOTHER'S MAIDEN NAME SARAH BUBESLOVSKY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-09-7675	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 008.1 IMMEDIATE CAUSE (a) RUPTURE OF EMPHYSEMATOUS BLEB & RT. PULMONARY COLLAPSE. DUE TO (b) ASTHMA, EMPHYSEMA, & ABSENCE OF FUNCTIONING LF. PULMONARY TISSUE DUE TO (c) SECONDARY TO POST-TUBERCULOUS THERAPY.		INTERVAL BETWEEN ONSET AND DEATH 4 HOURS 25 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1961, to NOV 1 , 1967, that (I) (we) last saw the deceased alive on NOV 1 , 1967, and that death occurred on NOV 1 , 1967, at 3:45 P.M., from causes and on the date stated above.			
22a. SIGNATURE Robert L. Krichmar		22b. DATE SIGNED NOV 1 1967	
22c. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR MD		22d. ADDRESS 7733 ARASKA AVENUE NW, WASHINGTON D.C. 20012	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 11-3-67	23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEM. INC.	23d. LOCATION (City or Town) (County) (State) Hyattsville, MD.
24. FUNERAL DIRECTOR Looney Heese & Co		25a. REC'D BY REGISTRAR NOV 3 1967	
ADDRESS 4217 9th Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MONTGOMERY STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>9119 Manchester Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fischer, Charlotte</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1889</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael Fast</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hahn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Leonore Fischer Raab</u>		Address <u>9039 Blisco Cr. Pkwy S.S.Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD & Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>approx 30 min.</u> <u>approx 4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF MEDICAL EXAMINATION Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 1964, to <u>Nov. 22</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov. 22</u> , 1967, and that death occurred at <u>10:56</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u>		22b. DATE SIGNED <u>Nov. 22, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bethesda, N.Y.</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>3501-14th Street, N.W. Washington, D.C. 20006</u>		DATE <u>NOV 27 1967</u>	

VR A15 (4)
25M 1/67

15582

15577

ESTIMATE IN DOLLARS

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and Manchester Rd

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2100 Spring
Holy Cross

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Feb. 22, 77

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15578

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>4 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15578	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14326 New Hampshire Ave.</u>				d. STREET ADDRESS <u>5014 Battery Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH A. FISCHER</u>				4. DATE OF DEATH <u>Nov. 10 1967</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19 '99 67</u>	
				9. AGE (In years Last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>	
13. FATHER'S NAME <u>John Fischer</u>				14. MOTHER'S MAIDEN NAME <u>Annie Weiss</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. A.F. Rosendorf (above) niece</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinsonism</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.				22. DATE SIGNED <u>Nov. 10, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>				DEPUTY MEDICAL EXAMINER <u>Charles Judge</u> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>		23b. DATE THEREOF <u>11-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>		23d. LOCATION (City or Town) (County) (State) <u>New Orleans Louisiana</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>3557 Wisconsin Ave Bethesda, Md</u>				25a. REC'D BY REGISTRAR <u>NOV 14 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Cleared by Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15583

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15579

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>		d. STREET ADDRESS <u>Hyattsville</u>	
3. NAME OF DECEASED (Type or print) <u>Daphne Jane Fletcher</u>		4. DATE OF DEATH <u>11 16 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-67</u>
9a. AGE (In years lost birthday) <u>9 mos</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frances X. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Gretchen Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7545</u> IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>67</u> to <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>S - Mahallati</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Salaheddin Mahallati</u>		22d. ADDRESS <u>1000 LEBRON SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>Francis Jallin</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 20 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15584

CERTIFICATE OF DEATH

15580

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town). <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10306 Haywood Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd N Fouke</u>		4. DATE OF DEATH Month Day Year <u>11 21 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/97</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>7 1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Engineering</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Fouke</u>		14. MOTHER'S MAIDEN NAME <u>Carrie McCoughney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>287-05-8350</u>	
17. INFORMANT <u>Hazyl G. Fouke-wife-same item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic</u> DUE TO (b) <u>Bronchogenic Carcinoma of</u> DUE TO (c) <u>Left Lung.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> to <u>Nov.</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov. 20</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Gelden R. Reap</u>		22b. DATE SIGNED <u>Nov. 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GELDEN R. REAP, M.D.</u>		22d. ADDRESS <u>Wheaton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>11/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ottawa Hills Mem. Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Toledo, Ohio</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 24 1967</u>	

1888

1888

RECORD OF NAME

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G396 11/15/67 ph

CERTIFICATE OF DEATH

15585

15581

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12h. 35 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>2700 Baker Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles A. Frahme</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/04</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Long Island N.Y.</u>	
13. FATHER'S NAME <u>Karl Frahme</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>055-05-5840</u>		17. INFORMANT <u>Helen Smallwood Drine Silver Spring</u> Address <u>4214 Rockledge</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, posterior wall, recent and old,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary arteriosclerosis and coronary thrombosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 4</u> , 19 <u>67</u> , to <u>Nov. 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>67</u> ; and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Stanley M Bialek</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-7-67</u>
22c. PHYSICIAN'S NAME (Type) <u>STANLEY BIALEK</u>			22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

0523

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2000

CERTIFICATE OF DEATH

15582

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN TB <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1001 Rockville Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>EVA</u> <u>Middle</u> <u>I.</u> <u>Last</u> <u>FRANKLIN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lexington, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Caleb M. Bouknight</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. Bouknight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-72-4356</u>	
17. INFORMANT <u>Mrs Frances E. Franklin-Item # 2</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d).) PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>70415</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>65</u> , to <u>11-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>8:10 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Henry M. Loudon</u>		22b. DATE SIGNED <u>11-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry M. Loudon</u>		22d. ADDRESS <u>5206 NORWAY DR. CHEVY CHASE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		23b. DATE THEREOF <u>11/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosemont</u>		23d. LOCATION (City or Town) (County) (State) <u>Newberry, S. Carolina</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1351 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		DATE <u>NOV 17 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12285

12285

RECEIVED
JAN 14 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15587

CERTIFICATE OF DEATH

15583

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md. 20906</u>	
c. LENGTH OF STAY IN lb <u>6 days</u>		d. STREET ADDRESS <u>1316 CHURCH HILL DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>F</u> Last <u>Fried</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-XX 91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md. BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID FRIED</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE FRIED</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-5725A</u>	
17. INFORMANT <u>MRS. RUTH WISEMAN</u>		Address <u>1316 CHURCH HILL DRIVE #8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>arteriosclerosis, coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>50 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral arteriosclerosis, & chronic toxemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>67</u> , to <u>11/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>67</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel R. Krison</u>		22b. DATE SIGNED <u>11/17/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MIKRO KODESH BETH ISRAEL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

15523

15523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15588

15584

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> 16-2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>21 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>620 Sheridan, ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LENA</u> <u>B</u> <u>FRIEDENBERG</u>		4. DATE OF DEATH Month Day Year <u>11</u> <u>3</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-91</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB KEROES</u>		14. MOTHER'S MAIDEN NAME <u>ROSE COHEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HARRY EISENSTADT</u>		Address <u>3917-15BELL, ST.</u> <u>S.S. MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>167</u> <u>11/3</u> <u>67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>67</u> , to <u>11/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>David Goldenberg</u>		22b. DATE SIGNED <u>11/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>		22d. ADDRESS <u>10620 GEORGIA SILVER SPRING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 42179th Drive</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

4322

11/10/1911

4323

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "Dear", "Yours", and "Sincerely" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
15589				CERTIFICATE OF DEATH				15585			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 35 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>28 W. Deer Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Infant Girl Frye</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1967</u>							
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-67</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Frye</u>				14. MOTHER'S MAIDEN NAME <u>Thelma Gale</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>776X</u>		17. INFORMANT <u>Thelma Gale</u>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Press. atort</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from <u>11/16/67</u> , 19 <u>67</u> , to <u>11/16/67</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>11/16</u> 19 <u>67</u> , and that death occurred at <u>9:50 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Mart Jones</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/16/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>MARVIN MOVES</u>				22d. ADDRESS <u>1003 Spring St S. Gaithersburg, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Hosp. disp.</u>		23b. DATE THEREOF <u>11-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Md.</u>					
24. FUNERAL DIRECTOR <u>Angela C. Carter / B. Admin.</u> <u>Suburban Hospital</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

7-264968

1958

1958

1958

1958



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

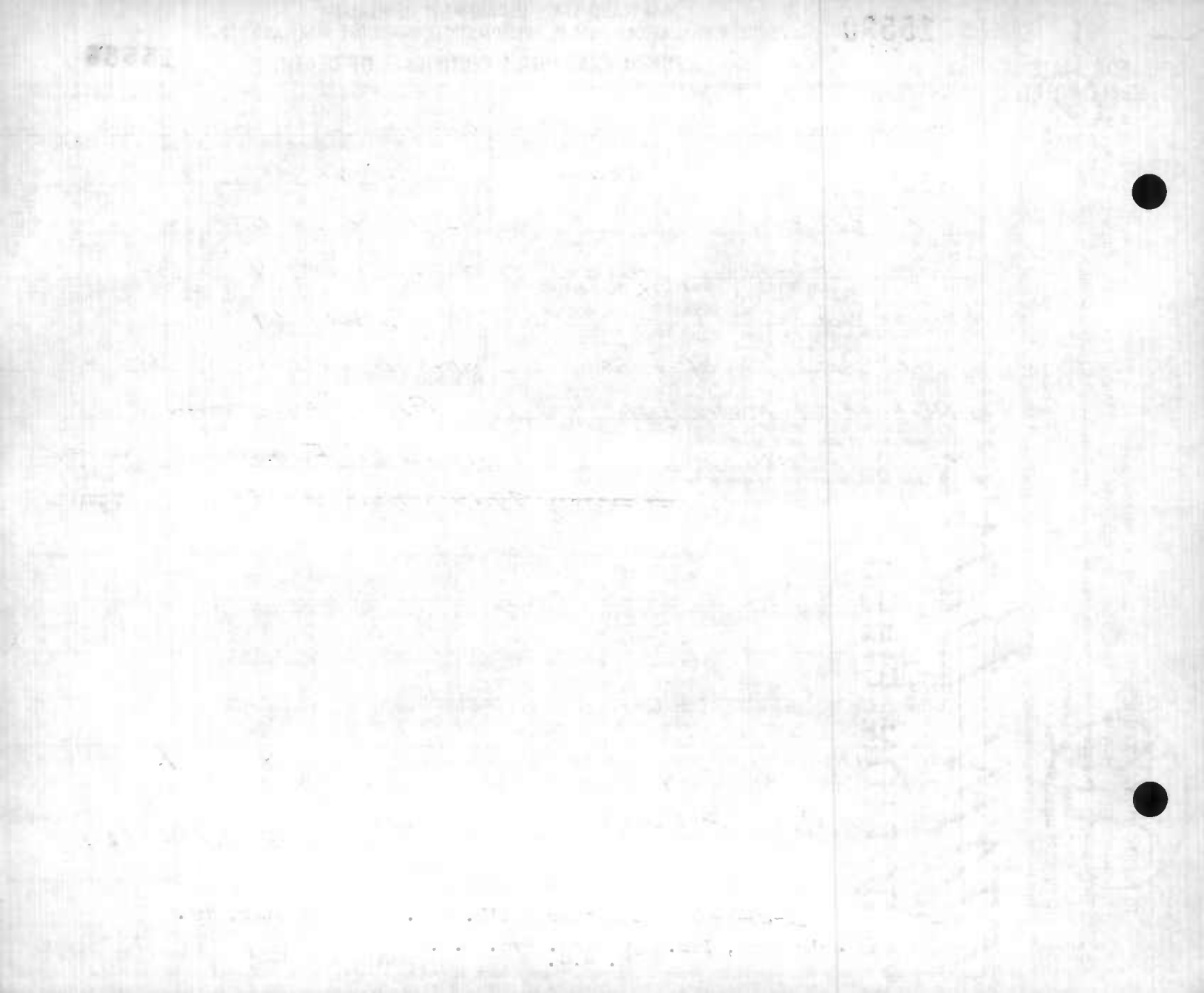
15530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15586

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>40 mins</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>			d. STREET ADDRESS <u>45-60 So. CHELSEA</u> LANE 35		
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS XAVIER FUHRMAN</u>			4. DATE OF DEATH Month Day Year <u>NOV 16 1967</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 35 1899</u>	9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTOMS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM FUHRMAN</u>			14. MOTHER'S MAIDEN NAME <u>ADA SWEETMAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes IT WW</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>KATHLEEN FUHRMAN - WIFE</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning Thrombosis Acute</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2m</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John B. Ball</u>		M.D.		22. DATE SIGNED <u>Nov. 16/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Re nova</u>	23b. DATE THEREOF <u>11-20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Culpeper Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Culpeper, Va.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W.</u> Wash. D.C.			25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



15591

CERTIFICATE OF DEATH

15587

1. PLACE OF BIRTH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		b. COUNTY Montg.	
c. LENGTH OF STAY IN 1b Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda/ Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium		d. STREET ADDRESS 3704 Huntington St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph		Middle Boyd	
Last Fuller		4. DATE OF DEATH Month Nov	
Day 14		Year 1967	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19, 1889
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 7	
IF UNDER 24 HRS. Days 14		Hours 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) MORRISTOWN N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Theodore Mulford		14. MOTHER'S MAIDEN NAME BESSIE BENTLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N o		16. SOCIAL SECURITY NO. Mrs. Edwin C. Hegg, Chevy Chase, Md.	
17. INFORMANT Mrs. Edwin C. Hegg, Chevy Chase, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - acute DUE TO (b) Advanced generalized arteriosclerosis DUE TO (c) 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/14/67 , 19__, to 11/14/67 , 19__, that (I) (we) saw the deceased alive on 11/14/67 , 19__, and that death occurred at 9:30 AM , from causes and on the date stated above			
22a. SIGNATURE Ronald W. Barr		22b. DATE SIGNED 11/14/67	
22c. PHYSICIAN'S NAME (Type) RONALD W. BARR, M.D.		22d. ADDRESS 10401 Old Georgetown Rd Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/15/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Joseph Gaultier's Sons 510 Wisconsin Ave		25a. REC'D BY REGISTRAR NOV 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1953

UNITED STATES OF AMERICA

1953



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15588

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>Brookville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		4. STREET ADDRESS <u>19923 Zion Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Howard S. Gant</u> First <u>S.</u> Middle <u>Gant</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17 1921</u>
9. AGE (In years <u>46</u> birthday yrs.)		IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Service Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Gant</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Diggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Extreme Injuries</u> DUE TO (b) <u>including Skull fractures</u> DUE TO (c) <u>with Exsanguination</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter picture of injury in Part I or Part II of item 18.) <u>Deceased, Driver, lost control of car which hit pole</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> p.m. <u>11-11</u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street Brookville, Md.</u>	20f. (City or town) <u>Montg.</u> (County) <u>Montg.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>MT. ZION, MONTG. MD.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Swarden</u> ADDRESS <u>ROCKVILLE, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>			d. STREET ADDRESS <u>2101 Hilda Rose Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Harry W.</u> Middle <u>Garis</u> Last <u>Garis</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1891</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor (Retired) U.S. Govt.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cornelius Garis</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Fleming</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT <u>Mrs. Eva Garis</u>		Address <u>2101 Hilda Rose Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>severe atherosclerosis</u> (c) <u>myocardial infarction</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>67</u> to <u>11/2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/1</u> , 19 <u>67</u> , and that death occurred at <u>6:35 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur J. Willets</u>					M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		22b. DATE SIGNED <u>11/2/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>November 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Easton Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Pennsylvania</u>		
24. FUNERAL DIRECTOR <u>J. B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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VR A15 (4)
20M 1/65

15590

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>18 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6800-Connecticut Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EuFROsune Dolly George</u>		4. DATE OF DEATH <u>November 6 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 18, 1918</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>8</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Theodore</u>		14. MOTHER'S MAIDEN NAME <u>Maria Stamos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>Multiple Sclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u> Hour a.m. <u>None</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1957</u> to <u>November 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 1967</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Loftus</u>		22b. DATE SIGNED <u>November 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. LOFTUS</u>		22d. ADDRESS <u>5415-Connecticut Ave. N.W. - Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Removal 11-6-67</u>		23b. DATE THEREOF <u>11-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Pr. Geo Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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John T. Moore

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15595

CERTIFICATE OF DEATH

15591

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			d. STREET ADDRESS 1106 Ednor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leo Middle Earl Last George			4. DATE OF DEATH Month November Day 14 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/13/88		9. AGE (In years lost birthday) yrs. 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Post office		11. BIRTHPLACE (County & State, or foreign country) Wisconsin	
13. FATHER'S NAME Benjamin B. George			14. MOTHER'S MAIDEN NAME Mary Atkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA AND PULMONARY EDEMA DUE TO (b) CEREBRAL HEMORRHAGE, LEFT DUE TO (c) ARTERIOSCLEROTIC VASCULAR DISEASE					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO PNEUMONIA - TERMINAL					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (1) this hospital attended the deceased from AUGUST 11-14, 1967 , that (1) (we) last saw the deceased alive on 11-13, 1967 , and that death occurred at 10:00 AM , from causes and on the date stated above.					
22a. SIGNATURE Donald R. Lewis			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-14-67
22c. PHYSICIAN'S NAME (Type) Donald Lewis, MD.			22d. ADDRESS Cloverly Road, Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION (City or Town) (County) (State) Cothran Manor, Md.		24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			
25a. REC'D BY REGISTRAR NOV 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

15585

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BRONCHO PNEUMONIA - TERMINAL
ARTERIOLECTIC VASCULAR DISEASE 20/5
GENERAL PNEUMONIA, LEFT
4 DAYS
GEMIA AND PNEUMONIA 2 DAYS

11-14-67
August 64 11-14 67

11-13-67
D. L. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15592

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 8hrs./4mins.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
3. NAME OF DECEASED (Type or print) William Henry Gittings First Middle Last 4. DATE OF DEATH November 15, 1967 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-85 9. AGE (In years lost, birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Plumbing and Heating		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME JOHN H. Gittings		14. MOTHER'S MAIDEN NAME Maggie Truxton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes - National Guard 1947-1950		16. SOCIAL SECURITY NO. 577-09-4424	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Nov. 16, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY CEAR HILL CEM	23d. LOCATION (City or Town) (County) (State) SUITLAND MD.
24. FUNERAL DIRECTOR W.W. CHAMBERS CO ADDRESS RIVERDALE, MD		25a. REC'D BY REGISTRAR NOV 20 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

22719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Alabama</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weaver</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Loyd</u> Last <u>Godbee</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 April 1955</u>
9. AGE (In years last birthday) <u>12</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	11. BIRTHPLACE (County & State, or foreign country) <u>France</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Loyd Godbee, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Lord</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>2043</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombocytopenia</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>10 months</u> <u>10 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diffuse Pulmonary Hemorrhage and Candidiasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 4</u> , 1967, to <u>Nov. 18</u> , 1967, that <input checked="" type="checkbox"/> (we) saw the deceased alive on <u>Nov. 18</u> , 1967, and that death occurred at <u>7:40 M.</u> from causes on and on the date stated above			
22a. SIGNATURE <u>Robert G. Graw, Jr., M.D.</u>		22b. DATE SIGNED <u>Nov. 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Graw, Jr., M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>Nov. 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <u>Calhoun Ala.</u>
24. FLUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle ALICE Last GODFREY		4. DATE OF DEATH Month 11 Day 2 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-84
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months 11 Days 2 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH HOLMES		14. MOTHER'S MAIDEN NAME MOLLY HOLMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MEDICAL RECORD DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Obstruction, common duct DUE TO (c) Carcinoma, head pancreas		INTERVAL BETWEEN ONSET AND DEATH Days mos. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Diabetes Mellitus ② Nephrosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1967 to 11-2, 1967 , that (I) (we) last saw the deceased alive on 11-2-67 , and that death occurred at 3:30P M, from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED 11-3-67	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MD.	
23a. BURIAL CREMATION, REMOVAL Burial		23b. DATE THEREOF 11-5-67	
23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR DATE NOV 7 1967	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

Emmons H. Lusk, Laytonville, Ia.

Serial 11-3-07 Laytonville

Laytonville, Mo. No.

JACK KENNEDY, Jr.,

LAYTONVILLE, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Washington Sanitarium and Hospital</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8207 Grubb Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>GOLDENZIEL</u> Last 4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>19 67</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 21, 1878</u> 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>502-46-7358A</u> 17. INFORMANT <u>Leon Weinraub</u> Address <u>1107 Dale Drive, Silver Spring</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ASCVD</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>66</u> to <u>Nov. 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>67</u> , and that death occurred at <u>6:45 AM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Marvin Schneider</u> 22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider, MD</u> 22d. ADDRESS <u>911 Silver Spring Ave., Silver Spring, Md</u>		22b. DATE SIGNED <u>November 2, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-5-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church Virginia</u> 23d. LOCATION (City or Town) (County) (State) <u> </u>		24. FUNERAL DIRECTOR <u>Donald M. Stein</u> <u>Hebrew Memorial Funeral Home Wash., DC 20012</u> 25a. REC'D BY REGISTRAR <u>NOV 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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THE STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15600				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15586							
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>		16-2									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN & Hospital</u>				d. STREET ADDRESS <u>6000 41st Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>GRACE</u> Last <u>GOODPASTURE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1967</u>											
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>7-20-92</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cal. Florida</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CAROL GOODPASTURE</u>				14. MOTHER'S MAIDEN NAME <u>Eda Schreiber</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-22-8640</u>		17. INFORMANT <u>Mr. A. Jife Heath</u> Address <u>4002 Nicholson St. Hyattsville, Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7054</u> IMMEDIATE CAUSE (a) <u>Septicemia - Pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Lupus Erythematosus</u> DUE TO _____								INTERVAL BETWEEN ONSET AND DEATH <u>3-6 days</u> <u>6-8 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Nov 11</u> , 19 <u>67</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>Nov 10</u> , 19 <u>67</u> , and that death occurred at <u>5:55 AM</u> , from causes and on the date stated above.															
22a. SIGNATURE <u>Robert B. Jrey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11-11-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. JREY</u>				22d. ADDRESS <u>11161 New Hampshire Ave Silver Spring</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>							
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 15 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

12222

OFFICE OF THE

12222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
15601		CERTIFICATE OF DEATH		15597	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 20016	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6677 Mac Arthur Blvd		d. STREET ADDRESS 6677 Mac Arthur Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Christopher Granger		4. DATE OF DEATH Month Nov Day 21 Year 1967			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov 25, 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mich	
13. FATHER'S NAME George F. Granger		14. MOTHER'S MAIDEN NAME Helena Mabley		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 579-60-2364		17. INFORMANT Stephen I. Granger Son Purcellville, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1934 to Nov 21, 1967 , that (I) (we) lost saw the deceased alive on Nov 6, 1967 , and that death occurred at 11:34 AM , from causes on and the date stated above.					
22a. SIGNATURE Worth B. Daniels M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 21, 67	
22c. PHYSICIAN'S NAME (Type) WORTH B. DANIELS		22d. ADDRESS 2001 Eye St NW Washington 6, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Nov 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Jos. Gawler Son's Inc. Wash, D.C.		25a. REC'D BY REGISTRAR DATE NOV 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18-21 Film 395
12-13-67 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15598

15602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b. <u>D.C.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2013 Edgewater Parkway</u>				d. STREET ADDRESS <u>2013 Edgewater Parkway</u>			
3. NAME OF DECEASED (Type or print) <u>William NMN GRAY</u>				4. DATE OF DEATH <u>November 14 1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-1-21</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		11. BIRTHPLACE (State or foreign country) <u>CANADA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PERCY GRAY</u>		14. MOTHER'S MAIDEN NAME <u>ESTHER TIDY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1948-1967</u>	
16. SOCIAL SECURITY NO. <u>551-18-2167</u>		17. INFORMANT <u>Alvin Gray</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO (b) <u>Barbiturate intoxication</u> DUE TO (c) <u>Barbiturate intoxication</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, depressed, took overdose of barbiturate</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>11/14 1967</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>Nov. 14 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pamphrey, Inc.</u>		8434 ADDRESS <u>Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15603

CERTIFICATE OF DEATH

17237

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4638 Livingston Road, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kerri Ann GREAM		4. DATE OF DEATH Month Day Year November 30 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1967
9. AGE (In years lost birthday) yrs. 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace Gream		14. MOTHER'S MAIDEN NAME Rita Marie Jobin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT S.E. Washington		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Congenital Coarctation of the Aorta DUE TO (c) Probable Intrauterine Infection CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Nov. 27 , 1967, to Nov. 30 , 1967, that (X) (we) lost the deceased on Nov. 30 , 1967, and that death occurred at 1250 PM , from causes and on the date stated above.			
22a. SIGNATURE Gene P. Swartz		22b. DATE SIGNED Dec. 1, 1967	
22c. PHYSICIAN'S NAME (Type) Gene P. SWARTZ M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-4-67	23c. NAME OF CEMETERY OR CREMATORY Stewart Cemetery	23d. LOCATION (City or Town) (County) (State) Dexter, Kentucky
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

MEDICAL CERTIFICATION

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15604

CERTIFICATE OF DEATH

15599

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 2 years		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5418 Glenwood Road		d. STREET ADDRESS 5418 Glenwood Road	
3. NAME OF DECEASED (Type or print) Mary E. Griffin		4. DATE OF DEATH Month Nov. Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1880
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 11 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Deucher		14. MOTHER'S MAIDEN NAME Martha A. Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Son J. Lloyd Griffin		18. ADDRESS 8009 Glenbrook Rd. Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cerebral Vascular Insufficiency DUE TO (c) Generalized Athero sclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hip Fracture			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 1967 to Nov. 11, 1967 , that (I) (we) lost the deceased on Nov. 10, 1967 , and that death occurred at 12:35 PM , from causes on and on the date stated above.			
22a. SIGNATURE Stanley M. Bialek		22b. DATE SIGNED Nov. 11, 1967	
22c. PHYSICIAN'S NAME (Type) STANLEY M. BIALEK		22d. ADDRESS 8218 Wisconsin Ave. Beth. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-15-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Buitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Item 8 Film 6394 11/10/67 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>1 Hr 45 min</u>		d. STREET ADDRESS <u>4318 Deland St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>Bordshell</u> Middle <u>Gumme</u> Last		4. DATE OF DEATH <u>Nov. 1 1967</u> Month <u>Nov.</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u> <u>May 24, 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Gumme</u>		14. MOTHER'S MAIDEN NAME <u>Boyer, Katherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>579-01-048</u>	
17. INFORMANT <u>Keneth Gumme - Colony Rd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> DUE TO (b) <u>2 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>11/2/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-4-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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11-9-77

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HARRY B. HACKMAN</u>		4. DATE OF DEATH <u>NOV 23 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25 - 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY T. HACKMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. KALER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT <u>W. M. HACKMAN</u> Address <u>1113 WATCHING AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> to <u>11/23</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>11/22</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Ronald W. Barr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR, MD</u>		22d. ADDRESS <u>10481 Old Georgetown Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>NOV. 27 - 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Church Cemetery, Bethesda, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Robert Waters</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 27 1967</u>			

18603

18603

ESTIMATE IN DOLLARS

PROHIBIT

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15607

CERTIFICATE OF DEATH

15602

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b Years Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10820 Georgia Avenue		d. STREET ADDRESS 10820 Georgia Avenue	
3. NAME OF DECEASED (Type or print) Charles M. Hardesty		4. DATE OF DEATH Month November Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/22/15
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Employee		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles P. Hardesty		14. MOTHER'S MAIDEN NAME Olive Padgett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-8139	
17. INFORMANT Donald P. Hardesty, Adelphi, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia to Brain - DUE TO Leukemia - Lymphosarcoma DUE TO Hypertension DUE TO 4y.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 3, 1967 , to Nov 4, 1967 , that (I) (we) last saw the deceased alive on Nov 3, 1967 and that death occurred at 3 AM , from causes and on the date stated above.			
22a. SIGNATURE AZAD J. Vosgenian		22b. DATE SIGNED Nov 4/67	
22c. PHYSICIAN'S NAME (Type) AZAD J. Vosgenian		22d. ADDRESS 3701 Magnolia Ave. NW - Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. 20016		25a. REC'D BY REGISTRAR NOV 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12522

12501

Gravice to Brain -
Leucobacillus - hypoglossus can. 4p.
Hypoglossus -

Handwritten notes and signatures at the bottom of the page, including "Mr. J. C. C." and "Mr. J. C. C.".

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15608

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15603

1. PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b. <u>I.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4005 - Myers Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Pearl T Harrison</u>		4. DATE OF DEATH <u>Nov. 25 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1919</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Marshall Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Lea Belle Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5811</u> <u>Bronchial Pneumonia -</u> DUE TO (b) <u>cirrhosis of Liver</u> DUE TO (c) <u>chronic Alcoholism -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>11/26/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>Nov. 30, 1967</u>	<u>Sandy Spring, Md.</u>	<u>Sandy Spring Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		25. REC'D BY REGISTRAR <u>Rockville, Md.</u>	
25a. DATE <u>DEC 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

20721

211331

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15609

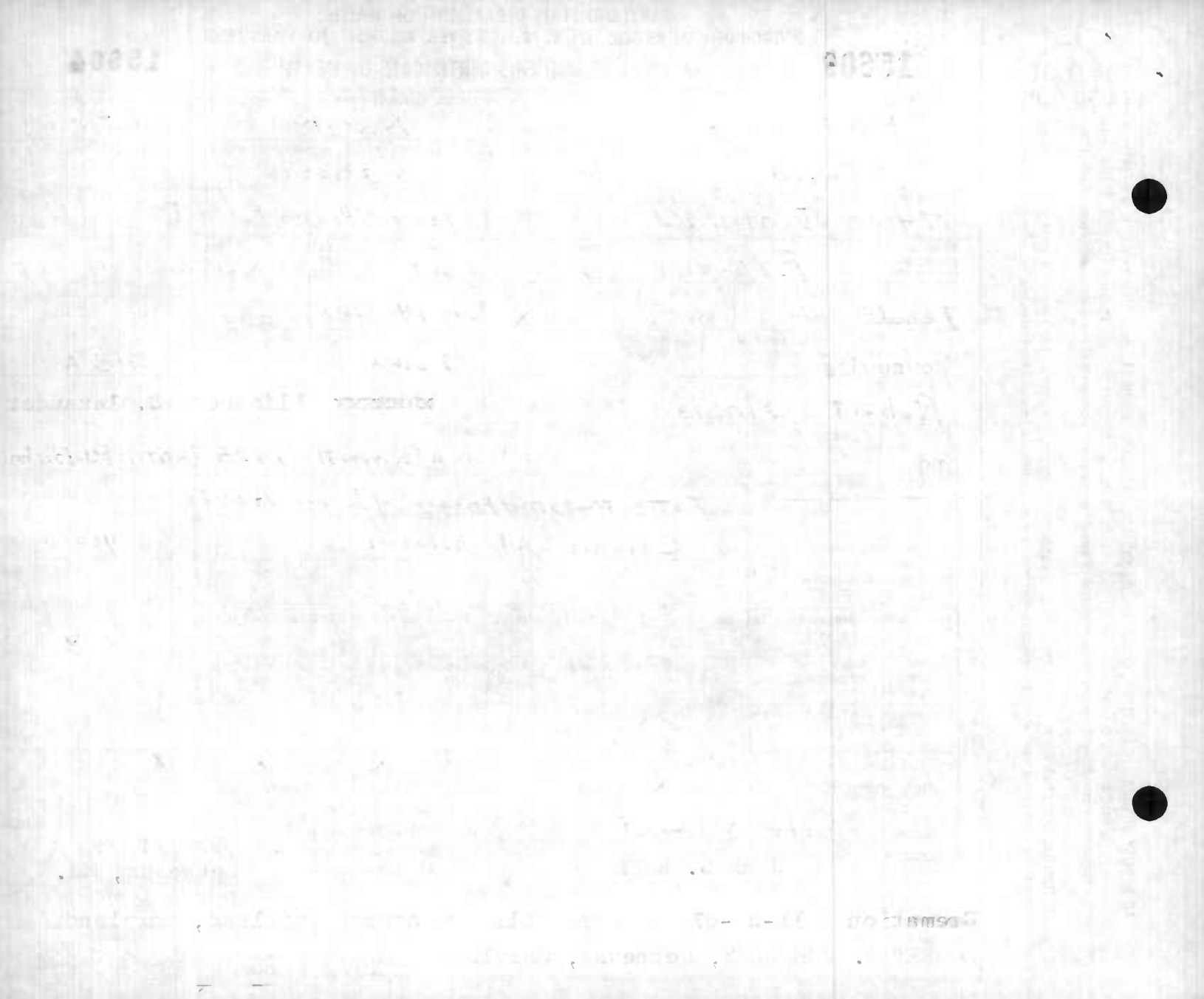
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15604

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7405 Denton Rd.</u>				d. STREET ADDRESS <u>7509 Springfield Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>S.</u> Last <u>Hart</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1907</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert S. Sinclair</u>				14. MOTHER'S MAIDEN NAME Unknown <u>Elizabeth S. Alexander</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>John A. Bennett 7405 Denton Rd Bethesda</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Metamorphosis of Liver Acute</u> DUE TO (b) <u>Chronic Alcoholism</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>Nov-18-1967</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15802

15802



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

15610

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15605

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth		d. STREET ADDRESS 205 Cedar Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mark Edward HEASTER		4. DATE OF DEATH Month Day Year November 2 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1967
9. AGE (In years last birthday) yrs. 1		10. BIRTHPLACE (County & State, or foreign country) Portsmouth, Va.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		12. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Heaster		14. MOTHER'S MAIDEN NAME Evangeline Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Dr. James M. Heaster, 205 Cedar Lane		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease DUE TO (b) Mitral & Aortic valve atresia DUE TO (c) 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 5:00 P.M. 10:30 P.M.	
21. I certify that (A) (this hospital) attended the deceased from Nov. 2 , 19 67 , to Nov. 2 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 2 , 19 67 , and that death occurred at 10:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jerry J. Tomasovic		22b. DATE SIGNED 10:30 P.M.	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/67	
23c. NAME OF CEMETERY OR CREMATORY CUNNINGHAM MEM. PARK		23d. LOCATION (City & Town) (County) (State) West Virginia	
24. FUNERAL DIRECTOR W. W. Chambers		25. REC'D BY REGISTRAR NOV 6 1967	
26. REGISTRAR'S SIGNATURE 1400 Chapin St., N.W. Washington, D. C.		27. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15611		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		Item #9 Film #G396 12/20/67 ph		15605	
CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beethesda</u> c. LENGTH OF STAY IN 1b <u>52 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> d. STREET ADDRESS <u>10101 Gary Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>m</u> Middle <u>Henderson</u> Last 5. SEX <u>m.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3/18/86</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			4. DATE OF DEATH <u>Nov.</u> <u>27</u> <u>19</u> <u>67</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		
13. FATHER'S NAME <u>Robert Richardson</u>			14. MOTHER'S MAIDEN NAME <u>Celia J. Van Wagoner</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>364-07-0290</u>		17. INFORMANT <u>Rachael Hart</u> Address <u>same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO (b) <u>Cerebral arteriosclerosis - Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>cerebral & general arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>7. Hip - (Lft.) - severe osteoarthritis - dislocated</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/1966</u> to <u>11/27/1967</u> , that (I) (we) last saw the deceased alive on <u>11/27/1967</u> , and that death occurred at <u>11/27/1967</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen H. Jones md</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/67</u>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1 Dec 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Albion Michigan</u>							
24. FUNERAL DIRECTOR <u>Charles Judge</u> ADDRESS <u>Box 1195 Washington, Michigan</u>		25d. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 29 1967</u>		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15612

15607

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Kings			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 454 - 76th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Cortright Last Henning				4. DATE OF DEATH Month November Day 14 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 June 1907		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysses Henning				14. MOTHER'S MAIDEN NAME Emma Ackley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 157-03-3946		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral infarction DUE TO (c) Rheumatic valvular heart disease							INTERVAL BETWEEN ONSET AND DEATH 5 days 6 days 30 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21 days following aortic valve replacement							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 22 October, 1967 , to 14 Nov., 1967 , that XX (we) last saw the deceased alive on 14 November 1967 , and that death occurred at 1:00 M. from causes and on the date stated above.							
22a. SIGNATURE Eric H. Johnson				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1967 14 November	
22c. PHYSICIAN'S NAME (Type) Eric H. Johnson, MD				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-17-67		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or town) (County) (State) Brooklyn, New York	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR NOV 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF COMMERCE

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>New Bern</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>68 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>402 Garner Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Jean</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1930</u>
9. AGE (In years last birthday) yrs. <u>37</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Henry Burke</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that <u>NO</u> (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>67</u> , to <u>Nov 24</u> , 19 <u>67</u> , that <u>W</u> (we) last saw the deceased alive on <u>Nov 24</u> , 19 <u>67</u> , and that death occurred at <u>1245</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rose B. Moquin</u>		22b. DATE SIGNED <u>24 November 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Cdr R. B. Moquin, USN</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>New Bern North Carolina</u>
24. FUNERAL DIRECTOR <u>Arnold F. Burner</u> <u>Cunningham Funeral Home, Alexandria, Va.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

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Vertical text on the right edge, possibly a page number or date, oriented vertically.

15614

CERTIFICATE OF DEATH

15609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014 The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>317 F Street, N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leroy (None) Hill</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 November 1913</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bennie Hill</u>				14. MOTHER'S MAIDEN NAME <u>Clara Lope</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Record, The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1550</u> IMMEDIATE CAUSE (a) <u>Hepatoma (Malignant Hepatoma)</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 24, 1967</u> , to <u>Nov. 15, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 15, 1967</u> , and that death occurred at <u>11:10</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>H. Thomas Foley, M.D.</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>16 November 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. Thomas Foley, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Switzland Md</u>			
24. FUNERAL DIRECTOR <u>Frogner 389 R.I. curw</u>		ADDRESS		25a. RECEIVED BY REGISTRAR <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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15615

CERTIFICATE OF DEATH

15610

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 20 Manchester Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald Jay Hillegas		4. DATE OF DEATH Month November Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-11
9. AGE (In years last birthday) 56 YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Inspector	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Albert Hillegas		14. MOTHER'S MAIDEN NAME Ada Faust	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior wall Myocardial Infarction DUE TO Arteriosclerosis (b) Diabetes Mellitus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28-67 , 19 67 , to Nov 23, 1967 that (I) (we) last saw the deceased alive on Nov 22, 1967 , and that death occurred at 4:00 M, from causes and on the date stated above.			
22a. SIGNATURE Boris Rabin		22b. DATE SIGNED Nov 23, 1967	
22c. PHYSICIAN'S NAME (Type) BORIS RABIN		22d. ADDRESS 1019 University Blvd East	
23a. BURIAL CREMATION, REMOVAL (Specify) Interment		23b. DATE THEREOF Nov. 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City or Town) (County) (State) Frederick, Md.	
24. FUNERAL DIRECTOR Arthur Waters		25a. REC'D BY REGISTRAR 254 Carroll St	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE NOV 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15616

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e. STREET ADDRESS <u>10019 RENTREW ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH E. HILLARY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/15</u>
9. AGE (In years lost birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>10</u> <u>00</u> <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Defense</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Springfield, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rou C. Chapin</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Colvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Donald H. Hillary</u>		Address <u>10,019 Rentrew Rd. S.S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Typhoid - Peritonitis</u> DUE TO (b) <u>Perforation Sigmoid</u> DUE TO (c) <u>Sigmoid Diverticulitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u> <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Nov 4, 1967</u> to <u>Nov 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 17, 1967</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John P. Haberlin</u> M.D.		22b. DATE SIGNED <u>11-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin M.D.</u>		22d. ADDRESS <u>1015 Spring Street Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Springfield Massachusetts</u>	
24. FUNERAL DIRECTOR <u>Watner E. Pumphrey Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div> <p>15617</p> <p>Items 8, 9, 13 & 14 Film G395 12/12/67 KK</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15612</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>				c. LENGTH OF STAY IN 1b <u>5 Mo 19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				15 1	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RANDOLPH HILLS Nsg. Home - 401 R</u>						d. STREET ADDRESS <u>4503 CLEARFIELD RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>D.</u> Last <u>HIRE</u>						4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/16/1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James William Hackler</u>						14. MOTHER'S MAIDEN NAME <u>NANCY FICKLER Fortner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>313-12-2589A</u>		17. INFORMANT <u>Hospital Records</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wide spread metastatic carcinoma</u> DUE TO <u>14yr</u> (c) <u>Carcinoma of breast</u> <u>14yr</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>11-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>67</u> , and that death occurred at <u>9 P.</u> M., from causes and on the date stated above.											
22a. SIGNATURE <u>Richard P. Delaney</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney, MD</u>						22d. ADDRESS <u>432 Howard St. Silver Sp. Md</u>					
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE THEREOF <u>11/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>			
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St. NE, Wash, DC</u>						25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Item #6 P.1. #6391 11/76/67 ph

15613

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase - Interden</u>		d. STREET ADDRESS <u>307 Congressional</u>	
3. NAME OF DECEASED (Type or print) <u>Edgar Jerome Hocutt</u>		4. DATE OF DEATH <u>Nov - 6 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research - NIH</u>	
13. FATHER'S NAME <u>Edgar J. Hocutt, 11</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cromartie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Same A s #2</u>	
17. INFORMANT <u>Maxine L. Hocutt</u>		Address <u>Same A s #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overdose, Morphine</u> DUE TO (b) <u>9701</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>intentional infusion of morphine</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>intentional infusion of morphine</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p.m. <u>11/6</u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Motel</u>	20f. (City or town) <u>Cherry Chase</u> (County) <u>Montgomery</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>11/8/67</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>11/8/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>	23d. LOCATION (City or Town) <u>Washington</u> (County) <u>D. C.</u> (State)
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St., NE, Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15613			
15614			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Greenbrier	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 19 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smoot		d. STREET ADDRESS (No street address)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilson Bernard Holliday		4. DATE OF DEATH Month Day Year November 18 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 May 1914
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Steuart Holliday		14. MOTHER'S MAIDEN NAME Maggie Brisinham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records Center, Bethesda, Maryland		20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wegener's Granulomatosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>30 October, 1967</u> , to <u>18 November 67</u> that <u>X</u> (we) lost saw the deceased alive on <u>18 November 19 67</u> , and that death occurred at <u>3:50AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Glenn L. Melson, II</u>		22b. DATE SIGNED 11/18/67	
22c. PHYSICIAN'S NAME (Type) Glenn L. Melson, M. D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-21-67	23c. NAME OF CEMETERY OR CREMATORY Wallace Mem. Cem.	23d. LOCATION (City or Town) (County) (State) Clintonville, W. Va.
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge NOV 24 1967	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15620

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15615

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 78 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 17630 Town Crest		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Greeley Middle Golden Last Holston				4. DATE OF DEATH Month November Day 21 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/2/31		9. AGE (In years last birthday) yrs. 36	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) superintendent		10b. KIND OF BUSINESS OR INDUSTRY landscaping		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Estal W. Holston				14. MOTHER'S MAIDEN NAME Stella E. Musser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address records, Montgomery General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liposarcoma, abdomen DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ 1971						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to Nov. 21, 1967 , that (I) (we) last saw the deceased alive on Nov. 21 19 67 , and that death occurred at 5: P.M. from causes and on the date stated above.							
22a. SIGNATURE Frederick Moomau M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-21-67	
22c. PHYSICIAN'S NAME (Type) Frederick Moomau, M. D.				22d. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 24 1967		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md	
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR DATE NOV 27 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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OFFICE OF THE

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN lb <u>14 DAYS</u>		d. STREET ADDRESS <u>5416 GLENWOOD RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>P</u> Last <u>HORN</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/88</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lincoln S. Horn</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Pinkeeton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-44-0278</u>	
17. INFORMANT <u>Helen - Wife - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>67</u> , to <u>11-20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-20</u> , 19 <u>67</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Montgomery</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. MONTGOMERY</u>		22d. ADDRESS <u>5411 CEDAR LANE BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15622

15617

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10102-Georgia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Hubert P. Hornsby</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ALLEN HORNSBY</u>		14. MOTHER'S MAIDEN NAME <u>EDITH PRIMM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>1917-1919</u>		16. SOCIAL SECURITY NO. <u>549-01-9290-A</u>	
17. INFORMANT <u>EDITH M. HORNSBY-10102 GA. AVE.</u>		Address <u>SILVER SP. MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive Heart Failure</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/7/67</u> to <u>4/8/67</u> , that (I) (we) last saw the deceased alive on <u>4/8/67</u> , and that death occurred at <u>150 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>11/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d. ADDRESS <u>10620 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-11-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Son</u> ADDRESS <u>5150 Wisconsin Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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DEPARTMENT OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cleveland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>87 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u>		72-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>1165 East 60th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>(NMN)</u> Last <u>Horzen</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1904</u>		9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Vidonja</u>				14. MOTHER'S MAIDEN NAME <u>Maria Titan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hypertension</u> DUE TO (b) <u>Mitral Stenosis</u> DUE TO (c) <u>Rheumatic Heart Disease</u> Interval between onset and death <u>410X</u> years <u> </u> years <u>30</u> years							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Post operative Starr-Edwards mitral valve replacement - 6 days</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u> </u> at work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>27 August</u> , 19 <u>67</u> , to <u>22 Nov.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>22 November</u> 19 <u>67</u> and that death occurred at <u>1:10 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Eric H. Johnson</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>22 Nov. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eric H. Johnson</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cleveland, Ohio</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15624

15619

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 hrs 40 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard</u>		d. STREET ADDRESS <u>6645 Barnaby St. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Hawell</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law Corp. of Engineers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Dr. J. J. Hawell</u>		14. MOTHER'S MAIDEN NAME <u>LEMING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. J. Hawell - Above</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO <u>ruptured abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>aneurysm</u> DUE TO <u>—</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>45</u> to <u>11/29/67</u> , that (I) <u>(two)</u> saw the deceased alive on <u>11/29/67</u> , and that death occurred at <u>9 P</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>Jay R. Shapiro</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAY R. SHAPIRO</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/4/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>Joseph Saulnier</u> ADDRESS <u>512 W. WIS. AVE. N.W. Washington D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15625		CERTIFICATE OF DEATH	
15620			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 Deer Park Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 151 d. STREET ADDRESS <u>100 Deer Park Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert H. HUFF</u> First Middle Last		4. DATE OF DEATH <u>Nov. 2, 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1903</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Robert H. Huff, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Victorina Jaffeau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Annie Lee Huff - wife same item #2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Metastatic Carcinoma lung</u> DUE TO (c) <u>Carcinoma of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>3 mo.</u> <u>5 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>67</u> , to <u>11/2</u> , 19 <u>67</u> , that (I) (we) lost the deceased on <u>10/25</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>E. H. Aschenbach</u>		22b. DATE SIGNED <u>11/2/67</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest H. Aschenbach</u>		22d. ADDRESS <u>1841 Columbia Rd., N.W., Wash., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 3 1967</u> 25b. REGISTRAR'S SIGNATURE	

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INSTRUMENT OF DEED

02321

BY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15626

CERTIFICATE OF DEATH

15621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 DALECARLIA ST.		d. STREET ADDRESS 7 Dalecarlia Street	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle E. Last Irwin		4. DATE OF DEATH Month 11 Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-1897
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months 11 Days 6	IF UNDER 24 HRS. Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Map		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marion English	
14. MOTHER'S MAIDEN NAME N.C. Bowling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 578-28-3412		17. INFORMANT Lottie Owens Address Falmouth, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/10/1967 to 11/6/1967 , that (I) (we) last saw the deceased alive on 11/6/1967 , and that death occurred at 9:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-9-67	
23c. NAME OF CEMETERY OR CREMATORY ROCK HILL CEM.		23d. LOCATION (City or Town) (County) (State) ROCK HILL VA	
24. FUNERAL DIRECTOR Robert A. DeWolf		25a. REC'D BY REGISTRAR Washington D.C.	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE NOV 13 1967	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner/med.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 911 Lamberton Drive	
3. NAME OF DECEASED (Type or print) First MORRIS Middle JACOBSON Last JACOBSON		4. DATE OF DEATH Month Nov. Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/07
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Laundry Equipment	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Louis Jacobson		14. MOTHER'S MAIDEN NAME Ida Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-01-6099	
17. INFORMANT David Jacobson (same as 2 above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary artery disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-11 , 19 52 , to 11-23 , 19 67 that (I) (we) last saw the deceased alive on 11-23 , 19 67 , and that death occurred at 4:21 P.M. from causes and on the date stated above.			
22a. SIGNATURE George J. Hageage		22b. DATE SIGNED 11-23-67	
22c. PHYSICIAN'S NAME (Type) George J. Hageage		22d. ADDRESS 3717-38th Ave. Cottage City	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-26-1967	23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.		25a. REC'D BY REGISTRAR DATE NOV 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15623										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>8912 Mohawk La</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Elizabeth Newcomb-Janeck</u>					4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/1874</u>		9. AGE (In years lost birthday) yrs. <u>93</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Lodi Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>John J. Newcomb</u>					14. MOTHER'S MAIDEN NAME <u>Delia S. Chusler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>535-09-0143</u>		17. INFORMANT <u>Daughter</u> <u>Mrs. Robert W. King</u>				Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, cerebrum, massive</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>58</u> to <u>Nov</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>11/26</u> , 19 <u>67</u> , and that death occurred at <u>4:25</u> M, from causes on and on the date stated above.										
22a. SIGNATURE <u>DR LEO I DONOVAN</u>					22b. DATE SIGNED <u>11/26/67</u>			22c. PHYSICIAN'S NAME (Type) <u>DR LEO I DONOVAN</u>		
22d. ADDRESS <u>8218 WISCAMUS Bethesda</u>					22e. ADDRESS <u>8218 WISCAMUS Bethesda</u>					
23a. BURIAL, CREMATION, or other disposition <u>Cremation</u>		23b. DATE THEREOF <u>11-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Suitland Pr. Geo Md</u>			
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CONTRACT NO. 10028

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15629 CERTIFICATE OF DEATH 15629									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>Rt #1 Box 268A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Ethel</u>		Middle <u>Mae</u>		Last <u>Johnson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6, 1967</u>		9. AGE (In years last birthday) <u>7</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Guy Lester Johnson</u>					14. MOTHER'S MAIDEN NAME <u>Thomasina Wilson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>7735</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> , 19 <u>67</u> , to <u>Nov 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>67</u> , and that death occurred at <u>24</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Morris Feitel</u>						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>MORRIS FEITEL MD</u>						22d. ADDRESS <u>704 Gorman Ave LAKE/ 18</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>						ADDRESS <u>1331 Rock Pike</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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RECEIVED
JUL 21 1964
U.S. AIR FORCE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME-1
6M 1/67

<div> <div>Items 10-21 Film 396 12-2</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div>									
<div> <div>15630</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>15625</div> </div>									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital					d. STREET ADDRESS 10204 Grenock Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Morris Edward Johnson					4. DATE OF DEATH Month 11 Day 16 Year 1967				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/07		9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant-Supervisor Wash Gas-Lt. Co			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert A. Johnson			14. MOTHER'S MAIDEN NAME Eva Bunch						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 577-07-7386		17. INFORMANT Silver Spring, Maryland Alida Johnson 10204 Grenock Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 Acute pulmonary embolization accompanied by DUE TO acute subdural hematoma and Leptomenigitis (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). Deceased fell at home before hospitalization, striking head						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-18 1967			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring Montg. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap M.D.			22. DATE SIGNED Nov. 18, 1967						
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						
23b. DATE THEREOF Nov. 20, 1967			23c. NAME OF CEMETERY OR CREMATORY St. Lincon Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Geo. County, Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave.					25a. REC'D BY REGISTRAR DATE NOV 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G395 11/28/67 ph

CERTIFICATE OF DEATH

15631

15626

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 473 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7036 EASTERN AVE. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES H. JONES		4. DATE OF DEATH Month 11 Day 11 Year 1967	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-18 9. AGE (In years lost birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELDERMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME McKinley Jones		14. MOTHER'S MAIDEN NAME Nettie Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942 to 1943		16. SOCIAL SECURITY NO. 1942 to 1943	
17. INFORMANT Betty C. Jones - wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1810 IMMEDIATE CAUSE (a) Pulmonary Metastases DUE TO (b) Carcinoma of Bladder DUE TO (c) 145		INTERVAL BETWEEN ONSET AND DEATH 145	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1966 to April 1967 , that (I) (we) last saw the deceased alive on 11/10 19 67 , and that death occurred at 5A M, from causes on and on the date stated above.			
22a. SIGNATURE J. Howard Jones		22b. DATE SIGNED 11/11/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-67	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR John T. R. Jones Co.		25a. REC'D BY REGISTRAR NOV 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15632

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15627

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Randall Last Jones		4. DATE OF DEATH Month November Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/19
9. AGE (In years and months) 48		10. IF UNDER 1 YEAR Months 4 Days 18 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Univ. of Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis R. Randall		14. MOTHER'S MAIDEN NAME Martha Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Medical Records	
17. INFORMANT Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, BRONCHOGENIC, RLL DUE TO (b) CARCINOMA, METASTATIC, LYMPH NODES, LIVER, BRAIN DUE TO (c) PULMONARY FIBROSIS, RT. LUNG		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY EDEMA, DIVERTICULOSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY , 19 67 , to NOV. 7 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 6 , 19 67 , and that death occurred at 9:31 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22d. ADDRESS Clarksville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-10-67	
23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		23d. LOCATION (City or Town) (County) (State) CLARKSVILLE, Md.	
24. FUNERAL DIRECTOR Harry Wm Knight		25a. REC'D BY REGISTRAR. DATE NOV 10 1967	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Jones	

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RECORDS OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) A34
6M 1/67
4/18/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15632

15628

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lee Middle Andrew Last Jordan JR.				4. DATE OF DEATH Month November Day 13 Year 1967			
5. SEX MALE		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1936	
9. AGE (In years lost birthday) 31 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Lee A. Jordan SR.				14. MOTHER'S MAIDEN NAME Helen MAY WARREN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO.				16. SOCIAL SECURITY NO.		17. INFORMANT Lee	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9160 DUE TO (b) Conflagration Burns of over 90% of body surface DUE TO (c) incurred in house fire							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Deceased burned in house fire			
20c. TIME OF INJURY Month, Day, Year 248 11-13-67				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
20f. (City or town) (County) (State) Takoma Park Montgom. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. READ, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Nov. 16, 1967				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial	
23d. LOCATION (City or Town) (County) (State) SANDY SPRING Montg. Md.				23e. REC'D BY REGISTRAR NOV 21 1967			
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.				25. REGISTRAR'S SIGNATURE Charles Judge			

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Anderson, Jordan T. November 13, 2017

28. 10. 1942

Handwritten: *Handwritten text, possibly a signature or name, and a date.*

7. 2010/10/17 10:00/2010/10/17

CERTIFICATE OF DEATH

15629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

Clara with Michael & Emma

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE M
Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hillandale | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | | d. STREET ADDRESS
311 Burnt Mills Road Ave | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Thomas | | First Thomas | | Middle Ward | | Last Joy | |
| 4. DATE OF DEATH
Nov. 4 | | Month Nov. | | Day 4 | | Year 1967 | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
28 November, '89 | |
| 9. AGE (In years last birthday)
77 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. Gov't | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Bernard F. Joy | | 14. MOTHER'S MAIDEN NAME
Harriet Ward | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Beatrice P. Joy (Same as # 2 D.) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a)
DUE TO Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO Coronary Arteriosclerosis
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized Atherosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr. 15 min. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/2/65 to 11/4/67 , that (I) (we) last saw the deceased alive on 11/4/67 , and that death occurred at 11:30 PM , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE
John J. Curry | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
11/4/67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
10620 Georgia Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Nov. 8, 67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cem | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
W. K. Huntmann & Son | | | | 25a. REC'D BY REGISTRAR
NOV 9 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT

Items 18-20 Film 395
11-20-67 am
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15630

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK
c. LENGTH OF STAY in 1b
DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SAN. & Hosp. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BELTSVILLE
d. STREET ADDRESS
4303 ELWOOD ROAD
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
KATHLEEN HARRIET KALEYIAS | | | 4. DATE OF DEATH
Month
NOVEMBER 2
Day
1967 | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
JULY 12, 1946 | | 9. AGE (In years last birthday)
21 yrs. | | IF UNDER 1 YEAR
Months
2
Days
16
Hours
22
Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STUDENT | | 10b. KIND OF BUSINESS OR INDUSTRY
UNIV. MD. | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
SPIROS KALEYIAS | | 14. MOTHER'S MAIDEN NAME
MARY HARRIS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-54-5471 | | 17. INFORMANT
Spiros Kaleyias Address
4303 Elmwood Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 816.4 Multiple extreme injuries including
DUE TO (b) severance of cervical spinal cord incurred
DUE TO (c) in auto accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased was driver of auto which crossed midline and collided with oncoming car. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
9:05 p.m. 11-2 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | | |
| 20f. (City or town)
Beltsville | | 20g. (County)
Pr. Geo. | | 20h. (State)
Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Read | | M.D.
BELDEN R. READ M.D. | | 22. DATE SIGNED
Nov. 3 1967 | | | |
| EXAMINER'S NAME (Type)
BELDEN R. READ | | DEPUTY MEDICAL EXAMINER
Wheeler | | 23a. REC'D BY REGISTRAR
NOV 8 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
November 6, '67 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | |
| 23d. LOCATION (City or Town)
Prince Georges | | 23e. (County)
Maryland | | 23f. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 23g. FUNERAL DIRECTOR
C. Glen Carter | | 23h. ADDRESS
Warner E. Pumphrey Inc. 8434 Georgia Ave. SS | | 23i. DATE
NOV 8 1967 | | | |

1232

WINTOMERY

THOMAS L. BROWN

WASHINGTON 20 4 HORN 403 KENNEDY ROAD

KATHLEEN HARRIET KENNEDY - NOVEMBER 2 67

EMILIE WHITE MAY 12 1948 21

STOEBT

SAIROS KALYIAS

KID 24-2711 KATHLEEN KENNEDY 107 HORN RD.

X

X X X X

JOHN R. KENNEDY - MAY 1948

JOHN R. KENNEDY - MAY 1948

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15631

15636

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seatonsda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>Box 36</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Patrick Anthony Karnes</u> | | 4. DATE OF DEATH <u>Nov. 14 1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/7/52</u> |
| 9. AGE (In years last birthday) <u>15</u> yrs. | | IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>47</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Patrick Karnes</u> | | 14. MOTHER'S MAIDEN NAME <u>Nancy Mc Glynn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>parents / same</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Skull fracture</u>
DUE TO (b) <u>automobile accident</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that ran off highway & hit a pole.</u> | | |
| 20c. TIME OF INJURY Month, Day, Year <u>Nov 14 1967</u> Hour o.m. <u>7:50</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | 20f. (City or town) (County) (State) <u>R. Seatonsda Mont. MD</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John L. Ball</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u> </u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 15 1967</u> | |
| | | Address (Street, city, town, or county) <u> </u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/17/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u> | 23d. LOCATION (City or Town) (County) (State) <u>Barnesville Mont-Md</u> |
| 24. FUNERAL DIRECTOR <u>William C. Hiltner, Barnesville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 20 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

10001

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X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15632

| | | | |
|---|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | d. STREET ADDRESS
9920 Georgia Ave., Apt. #3 | |
| 3. NAME OF DECEASED (Type or print)
First PEARL Middle D. Last KASOFSKY | | 4. DATE OF DEATH
Month Nov. Day 10 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1899 |
| 9. AGE (In years and birth day)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY
Jewelry | |
| 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Issac Aeurbach | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-05-9909 | |
| 17. INFORMANT (Son) Silver Spring, Md.
Jack Kasofsky - Caddington St., | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension - Asthma | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Belden R. Keap M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED Nov. 11, 1967 | | 23. REC'D BY REGISTRAR Nov. 13 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11-12-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Geo. Wash. Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hyattsville, Md. | |
| 24. FUNERAL DIRECTOR
Good Shepherd Home KUTSKOW INC | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

11437

12333

10/10/1961

10/10/1961

11/10/1961

11/10/1961

12/10/1961

12/10/1961

13/10/1961

13/10/1961

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16/10/1961

16/10/1961

17/10/1961

18/10/1961

19/10/1961

20/10/1961

21/10/1961

22/10/1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15639 CERTIFICATE OF DEATH 15633

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>2 yrs 3 mo.</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | d. STREET ADDRESS <u>8301 16th Street</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Aguiinas Keelan</u> | | | | 4. DATE OF DEATH Month Day Year <u>Nov 16 1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 15 1892</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Company</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Thomas Keelan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Leonard</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1917-1918</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>Dr. Thomas Keelan Jr. Tenley Bldg. Rockville, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> (b) <u>Chronic Cerebrovascular</u> (c) <u>nefro sclerosis</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>16 Nov 1967</u> , that (I) (we) last saw the deceased alive on <u>16 Nov 1967</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert C. Haile</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/16/67</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert C. Haile</u> 22d. ADDRESS <u>35 N.Y. Ave. N.W. Wash. D.C.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE THEREOF <u>Nov 18, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | 23d. LOCATION (City, town or county) (State) <u>Wheaton, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph GAWLERS SONS</u> 5730 WISE AVE. NW WASH. D.C. | | | | 25a. REC'D BY REGISTRAR <u>John Charles Judge</u> 25b. REGISTRAR'S SIGNATURE | | | |
| DATE <u>NOV 24 1967</u> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15633

CERTIFICATE OF DEATH

15634

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE District of Columbia
b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
8 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Resmor Hospital | | d. STREET ADDRESS
3212 Macomb Street, N. W. | |
| 3. NAME OF DECEASED
(Type or print) Alice M. KEITH. | | 4. DATE OF DEATH
Month Nov. Day 27 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 2, 1872 |
| 9. AGE (In years lost birthday) yrs.
95 | | IF UNDER 1 YEAR
Months 10 Days 4 Hours 5 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Herman Munhall | | 14. MOTHER'S MAIDEN NAME
Mary Piper | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Nathaniel S. Keith | | Address Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4500 IMMEDIATE CAUSE (a) ARTERIO SCLEROSIS -
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
INTERVAL BETWEEN ONSET AND DEATH
10 yrs + | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral Sclerosis - | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1935 to 11-27- 19 67 , that (I) (we) last saw the deceased alive on 11-27-67 19 67 , and that death occurred at 5:45 PM from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Wynne Post Baker | | 22b. DATE SIGNED
11-27-67 | |
| 22c. PHYSICIAN'S NAME (Type) WYNNE POST BAKER - | | 22d. ADDRESS
1635 HARVARD ST. N.W. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
11-28-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
DEC 4 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

18034

REPORT OF DEATH

18034

THE STATE OF TEXAS

COUNTY OF DALLAS

THIS DEATH CERTIFICATE

WAS

FILED FOR RECORD

ON

THE

10TH DAY OF

APRIL 1903

AT THE CITY OF DALLAS

IN THE COUNTY OF DALLAS

STATE OF TEXAS

DEATH CERTIFICATE

FILED FOR RECORD

ON THE 10TH DAY OF APRIL 1903

15640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Ohio b. COUNTY Trinway | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy XXX Cross Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Sheldon A. Keith | | 4. DATE OF DEATH
Month 28 , Day Nov , Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
14, Aug, 92 |
| 9. AGE (In years lost birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 19 Hours 19 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 11b. KIND OF BUSINESS OR INDUSTRY
PENN. R.R. | |
| 12. BIRTHPLACE (State or foreign country)
W. VA. | | 13. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. FATHER'S NAME
LEWIS E. KEITH | | 15. MOTHER'S MAIDEN NAME
ELVA MAY ALEXANDER | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 17. SOCIAL SECURITY NO.
A-888043 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO (b) Coronary Artery Heart Disease
DUE TO (c) Coronary Artery Heart Disease | | 19. INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 21c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 21f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Keap | | 22. DATE SIGNED
Nov. 28, 1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. KEAP M.D. | | DEPUTY MEDICAL EXAMINER
Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
11-28-67 | 23c. NAME OF CEMETERY OR CREMATORY
DRESDEN CEMETERY | 23d. LOCATION (City or Town) (County) (State)
DRESDEN, OHIO |
| 24. FUNERAL DIRECTOR
Francis J. Collins | | 25a. REC'D BY REGISTRAR
WASH.D.C. | |
| 25b. REGISTRAR'S SIGNATURE
Francis J. Collins | | DATE
DEC 1 1967 | |

15832

THE NEW YORK PUBLIC LIBRARY

15832

Ohio

CHICAGO

St. Louis

Box

St. Louis

Box 214

Holy Cross Hospital

22, Nov, 27

Keith

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73

14, Aug, 22

IX

Male White

15832

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Pennsylvania</u> b. COUNTY <u>75-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>61 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | d. STREET ADDRESS
<u>6 Pennsylvania Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Marjorie Jane Kessinger</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 28, 1927</u> |
| 9. AGE (In years last birthday)
<u>40</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Bank</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>J. Russell Gallagher</u> | | 14. MOTHER'S MAIDEN NAME
<u>Florence Hoffard</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>190-22-1426</u> | |
| 17. INFORMANT
<u>The Medical Record</u> | | Address
<u>The Clinical Center, Bethesda, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
<u>2001</u> IMMEDIATE CAUSE (a) <u>Lymphosarcoma, generalized</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Laryngeal obstruction due to lymphosarcoma</u>
DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>9 years</u>
<u>7 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 8</u> , 19 <u>67</u> , to <u>Nov. 8</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 8</u> , 19 <u>67</u> , and that death occurred at <u>6:00 AM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Bruce A. Chabner</u> | | 22b. DATE SIGNED
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>8 November 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Bruce A. Chabner, M.D.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11/11/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Lock Haven, Pennsylvania</u> | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 10 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10112

10112

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.
JANUARY 1, 1901
SIR,
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter of the proposed amendment to the act of March 3, 1879, relating to the sale of land in the public domain.
The Department is at present engaged in a study of the subject, and it is hoped that a report will be made to the Congress at an early date.
Very respectfully,
J. B. HARRIS, Secretary.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15642

CERTIFICATE OF DEATH

15637

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| c. LENGTH OF STAY IN <u>4 mos. 24 days</u> | | 16-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u> | | d. STREET ADDRESS <u>1310 Chillum Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Raymond Homer Kidwell</u> | | 4. DATE OF DEATH
Month <u>11</u> - Day <u>10</u> - Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Wh</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-10-15</u> |
| 9. AGE (In years lost birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Feterman Hardware</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Raymond G. Kidwell</u> | | 14. MOTHER'S MAIDEN NAME <u>Estelle Hamack</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>225-05-0582</u> | |
| 17. INFORMANT <u>Hospital record</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma prostate</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>9-10 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Nov 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> , 19 <u>67</u> , and that death occurred at <u>3:51 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>11-10-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u> | | 22d. ADDRESS <u>11161 New Hampshire Ave S.S.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/13/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 15 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

15638

15643

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

99
Med. Cert. approved or sealed

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | |
| c. LENGTH OF STAY IN 1b
<u>D.O.A</u> | | d. STREET ADDRESS
<u>118 Normandy Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>VIVIAN</u> Middle <u>LOUISE</u> Last <u>Kinchebe</u> | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>12</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>DEC 22-1906</u> |
| 9. AGE (In years last birthday) yrs. <u>60</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>BRISTOL TENN.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>WILLIAM FRANK SMITH</u> | | 14. MOTHER'S MAIDEN NAME
<u>Blanche Morgan</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>408-32-6354</u> | |
| 17. INFORMANT (husband) Address (Same)
<u>Lyle M. Kinchebe</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
DUE TO (b) <u>Multiple Metastases from Breast</u>
DUE TO (c) <u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Diabetes - Previous Coma</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>On 11/12, 1967</u> , to <u>D.O.A. 11/12</u> , that (I) (we) last saw the deceased alive on <u>11-1</u> <u>1967</u> , and that death occurred at <u>6 A</u> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Rich. L. Riddick</u> | | 22b. DATE SIGNED
<u>11-12-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Rich. L. Riddick</u> | | 22d. ADDRESS
<u>1835 Eye St. N.W. Wash. DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Nov. 15, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>National Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Falls Church, Virginia</u> |
| 24. FUNERAL DIRECTOR
<u>Glen Carter</u>
<u>Warner C. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR
<u>8434 Georgia Avenue</u>
<u>Silver Spring, Md.</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

2000

1900-1901

UNITED STATES DEPARTMENT OF AGRICULTURE

1900-1901

15644

15639

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE <u>Maryland</u> COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. STREET ADDRESS <u>7801 Hamilton Spring Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Theodor Knudsen</u> | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX <u>m.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/24/1889</u> |
| 9. AGE (In years last birthday) <u>78</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Business</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Peter Knudsen</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Lorenzen</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>Paula Knudsen</u> | | Address <u>same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction recent and remote</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary thrombosis and arteriosclerosis</u>
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "a.m." _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14</u> , 19 <u>67</u> , to <u>Nov. 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> 19 <u>67</u> , and that death occurred at <u>4:30</u> P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ronald Barr, M.D.</u> | | 22b. DATE SIGNED <u>11/17/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>RONALD BARR</u> | | 22d. ADDRESS <u>10401 Old Georgetown Rd Bethesda, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>11/18/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Calver Manassas Park Md</u> |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers, Inc</u> | | 25a. REC'D BY REGISTRAR <u>NOV 20 1967</u> | |
| ADDRESS <u>Silver Spring Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

The New York Public Library
 Astor Lenox and Tilden Foundations
 455 Fifth Avenue
 New York, N.Y. 10018
 Tel. (212) 854-2400
 Fax (212) 854-2401
 E-mail: nypl@nypl.org
 Website: www.nypl.org

The New York Public Library
 Astor Lenox and Tilden Foundations

15645

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | c. LENGTH OF STAY IN lb
<u>35 YRS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>11508 OREDAUGH AVE</u> | | d. STREET ADDRESS
<u>2922 ELLICOTT TERR. N.W.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>SAMUEL</u> First Middle Last <u>- KULCHINSKY</u> | | 4. DATE OF DEATH
Month <u>NOV.</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>APRIL 12, 1887</u> |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MERCHANT</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>HARRY KULCHINSKY</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>219-32-1319</u> | |
| 17. INFORMANT
<u>MR. HARRY KULLEN</u> Address <u>3600 WOODVALLEY DRIVE</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
DUE TO
(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO
(c) <u>DIABETES MELLITUS</u> | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u>
<u>5 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>DIABETES MELLITUS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o.m. <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>NOV. 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>NOV. 14, 1967</u> , and that death occurred at <u>4:45</u> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Saul Zuckerman MD</u> | | 22b. DATE SIGNED
<u>11-15-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>SAUL ZUCKERMAN, MD</u> | | 22d. ADDRESS
<u>5410 CONNECTICUT AVE. WASHINGTON, D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>11-16-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>BETH EL MEMORIAL PARK</u> | 23d. LOCATION (City or Town) (County) (State)
<u>RANDALLSTOWN, MD.</u> |
| 24. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 17 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

4380

4380

CHURCH OF GOD

1

15646

CERTIFICATE OF DEATH

15641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring
c. LENGTH OF STAY IN 1b
Washington | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Dist. of Col.
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
473 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | d. STREET ADDRESS
4517 43rd Place, N.W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First GERARD Middle L. Last Kyle | | 4. DATE OF DEATH
Month 11 Day 26 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-3-1901
9. AGE (In years last birthday)
66 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer - Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Gov't. Printing | |
| 11. BIRTHPLACE (County & State, or foreign country)
Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Kyle | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
- - - - - | | 16. SOCIAL SECURITY NO.
- - - - - | |
| 17. INFORMANT
Julia M. Kyle - Wife - See Item No. 2. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure
DUE TO (c) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
years
year
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Cerebral thrombosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/22/67 to 11/26, 1967 that (I) (we) last saw the deceased alive on 11/26/67 , and that death occurred on 11/26/67 from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John J. Curry | | 22b. DATE SIGNED
11/26/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John J. Curry | | 22d. ADDRESS
18620 Georgia Rd Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11-29-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. | |
| 24. FUNERAL DIRECTOR
Joe Goulet's Sons | | 25a. REC'D BY REGISTRAR
5150 WISC. AVE NW WASH. D.C. | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
DEC 4 1967 | |

1043

12021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA
c. LENGTH OF STAY IN 1b
38rs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville
d. STREET ADDRESS
728 HARRINGTON Rd
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
BABY STACIS ELIZABETH LEA
First Middle Last
4. DATE OF DEATH
Nov. 11 1967
Month Day Year | | 5. SEX
FEMALE
6. COLOR OR RACE
WHITE
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
Nov 11 1967
9. AGE (In years lost birthday) yrs.
3
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INDUSTRY
11. BIRTHPLACE (County & State, or foreign country)
BETHESDA, MD
12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
ELLIS LEA JR.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO
16. SOCIAL SECURITY NO.
7705
17. INFORMANT
BARBARA FINN
Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Erythroblastosis fetalis
7705 DUE TO Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 11/11 , 1967, to 11/11 , 1967, that (I) (we) last saw the deceased alive on 11/11 1967, and that death occurred at 12:30 PM , from causes on and on the date stated above.
22a. SIGNATURE
Moises Steren
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)
MOISES STEREN
22d. ADDRESS
50 W. Edmondston Ave., Rockville, Md.
22b. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
23b. DATE THEREOF
11/14/67
23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven
23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. | | 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home
25a. REC'D BY REGISTRAR
NOV 16 1967
25b. REGISTRAR'S SIGNATURE
Charles Judge | |

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MONTGOMERY STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15643 | | | |
|---|---------------------------|---|---------------------------------|---|---|--|--|-------|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>30 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | 15-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>10823 Georgia Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>V.</u> Last <u>Leedi</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u> | | | | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/23/08</u> | 9. AGE (In years lost birthday) <u>59</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Oregon, Widenburg</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME <u>WILLIAM GILBERT</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CHARLOTTA MATTHIESSEN</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>195-26-228</u> | | 17. INFORMANT <u>Husband - Arnold Leedi</u> Address <u>Same as above</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Undifferentiated carcinoma, stomach, (linitis plastica)</u>
DUE TO <u>151X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11, 1967</u> , to <u>Nov. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/20 1967</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Frederick Y. Donn</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>11/21/1967</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK Y. DONN</u> | | | | 22d. ADDRESS <u>10400 Conn. Ave. - Kensington, MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 23b. DATE THEREOF <u>11/27/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fresh Lincoln Crematory</u> | | 23d. LOCATION (City or Town) (County) (State) <u>COLMAR MARSH PARK, MD</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. - SILVER SPRING, MD</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

100

15644

CERTIFICATE OF DEATH

15643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington, Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Arlington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Kensington Gardens Sanitarium</u> | | d. STREET ADDRESS
<u>1716 N. TROY STREET</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Louise</u> Middle <u>A.</u> Last <u>Lewis</u> | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/4/1880</u> |
| 9. AGE (In years last birthday)
<u>87</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>GOVERNMENT</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>VIRGINIA</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>FREDERICK Aldridge</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Didie, Franklin</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | |
| 16. SOCIAL SECURITY NO.
<u>230-40-3967</u> | | 17. INFORMANT
Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
DUE TO _____
(b) _____
DUE TO _____
(c) <u>generalized arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs</u>
<u>20 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a.m. _____ p.m. _____ | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>4/21</u> | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>66</u> , to <u>11/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>67</u> , and that death occurred at <u>3:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | 22b. DATE SIGNED
<u>11/18/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. F. Kreuzburg</u> | | 22d. ADDRESS
<u>7552 16th St NW Washington DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Nov. 21, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National Cem.</u> | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____ |
| 24. FUNERAL DIRECTOR
<u>Ives Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>2847 Wilson Blvd. Arlington, Virginia</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | DATE <u>NOV 22 1967</u> | |

432

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form -PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN lb
DOA | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | 16-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SAN. & HOSP. | | d. STREET ADDRESS
8208 NEW HAMPSHIRE AV. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
MARY LILLIAN LISK | | 4. DATE OF DEATH
Month 11 - Day 27 - Year 1967 | |
| 5. SEX
Fe | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-25-95 |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
GEORGE WILHELM | | 14. MOTHER'S MAIDEN NAME
JULIE RITCHIE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MISS JULIE LISK | | Address
SAME - DTR. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap
EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | 22. DATE SIGNED
Nov. 27, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
Nov 28, 1967 | 23c. NAME OF CEMETERY OR CHURCH
Lefler Funeral Home | 23d. LOCATION (City or Town) (County) (State)
Albemarle North Carolina |
| 24. FUNERAL DIRECTOR
F. Gasch'S Sons | | ADDRESS
Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR
DEC 1 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

252

1024

174 202 - 1014

728 1-330

15651

CERTIFICATE OF DEATH

15646

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>43 Days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Md. 20014</u> | | d. STREET ADDRESS
<u>Ijamsville, Maryland</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Sarah Rosella Long</u> | | 4. DATE OF DEATH
Month Day Year
<u>November 11 19 67</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>10 September 1916</u> 51 yrs. |
| 9. AGE (In years lost birthday)
<u>51</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Registered Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Nursing Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Milton Younkin</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emma McKenzie</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-34-9608</u> | |
| 17. INFORMANT
<u>The Medical Records</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO
(b) <u>Scleroderma Kidney</u>
DUE TO
(c) <u>Progressive Systemic Sclerosis</u> | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
<u>5 weeks</u> | | 20. INTERVAL BETWEEN ONSET AND DEATH
<u>8 Weeks</u> | |
| 21. INTERVAL BETWEEN ONSET AND DEATH
<u>12 Months</u> | | 22. INTERVAL BETWEEN ONSET AND DEATH
<u>12 Months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>29 Sept.</u> , 19 <u>67</u> , to <u>11 Nov.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11 Nov.</u> , 19 <u>67</u> , and that death occurred at <u>2:30 M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Harry R. Keiser M.D.</u> M.D. | | 22b. DATE SIGNED
<u>11 November 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Harry R. Keiser, MD.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Nov. 14, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORIUM
<u>Grantsville</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Grantsville, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Francis J. Collins</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 14 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10000

DEPARTMENT OF STATE

10000

[Faint, mostly illegible text and markings covering the page, including what appears to be a large circular stamp or seal in the center.]

15652

CERTIFICATE OF DEATH

15647

| | | | | | | | |
|---|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>4 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | | | d. STREET ADDRESS
<u>1600 Pennsylvania Avenue, N.W.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ferdinand</u> Middle <u>(none)</u> Last <u>Louvat</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>20</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
<u>February 8, 1914</u> 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Pastry Chef</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government (The White House)</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>France</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Ferdinand Louvat</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Felicie Tocat</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>155-34-0244</u> | | 17. INFORMANT
<u>The Medical Record</u>
<u>The Clinical Center, Bethesda, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u>
DUE TO (b) <u>Rhabdomyosarcoma, Metastatic to Lungs</u>
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 Year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>20 November 1967</u> , to <u>20 Nov., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 November 1967</u> , and that death occurred at <u>9:50 M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Jean B. de Kernion</u> | | | | P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>11/22/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Jean B. de Kernion, M. D.</u> | | | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>Nov. 27, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>VOIRON</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>VOIRON, FRANCE</u> | |
| 24. FUNERAL DIRECTOR
<u>H. Don, DeVos</u> | | | | 25a. REC'D BY REGISTRAR
<u>2222 WIS. AVE. NW</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12221

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|--|--|---|---|--|--------------------------------|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 15653 | | | | | CERTIFICATE OF DEATH | | | | | 15648 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Dist. of Col.</u> b. COUNTY <u>-</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | | | | 47-3 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Potomac Valley Nursing Home</u> | | | | | d. STREET ADDRESS
<u>5147 Massachusetts Ave. N.W.</u> | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>ADA ELIZABETH</u> Middle <u>LUEDTKE</u> Last | | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>6</u> Year <u>1967</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-29-1877</u> | | 9. AGE (In years last birthday)
<u>90</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>- - -</u> | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Alabama</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME
<u>Jonas Aderholdt</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Frances Carpenter</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Address <u>Wash. D.C.</u>
<u>Mrs. Cecilia L. Moore, 5147 Mass. Ave. N.W.</u> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA LEFT BREAST</u>
<u>170X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>WITH GENERALIZED METASTASES</u> DUE TO
(c) <u>15 MONTHS</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JULY 10</u> , 19 <u>67</u> , to <u>NOV 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>NOV. 6</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Charles J. [Signature]</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Nov 6, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>11-9-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l. Cem.</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Arlington, Va.</u> | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc.</u> | | | | | ADDRESS
<u>5130 Wisc. Ave. N.W.</u>
<u>Wash. D.C.</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|-------------------------------|---|---|
| 15654 | | | |
| CERTIFICATE OF DEATH | | | |
| 15649 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS <u>4003 Byrd Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Elsie</u> First <u>Mae</u> Last | | 4. DATE OF DEATH
Month <u>November</u> , Day <u>19</u> , Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-18-93</u> |
| 9. AGE (In years lost birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR
Months <u>7</u> Days <u>14</u> Hours <u>15</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Fellers</u> | | 14. MOTHER'S MAIDEN NAME <u>Antonia Helintz</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-32-5341</u> | |
| 17. INFORMANT <u>Amy R. Fellers</u> | | Address <u>4003 Byrd Road Kensington, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid colon</u>
DUE TO (b) <u>Carcinoma of sigmoid colon</u>
DUE TO (c) <u>about 1 year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1967</u> , to <u>Nov. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/8/67</u> , 19____, and that death occurred at <u>7:25 PM</u> , from causes and on the date stated above. | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>11/19/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MICHAEL S. MADELOFF M.D.</u> | | 22d. ADDRESS <u>10620 Georgia Ave. Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/22/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>GREENHILL CEMETERY</u> | | 23d. LOCATION (City or Town) <u>MARTINSBURG W. Va.</u> (County) _____ (State) _____ | |
| 24. FUNERAL DIRECTOR <u>Donald Eckles-Hughes, W. Va.</u> | | 25a. REC'D BY REGISTRAR <u>[Signature]</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | DATE <u>NOV 22 1967</u> | |

1882

DEPT. OF AGRICULTURE

1882



RECEIVED

U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

CERTIFICATE OF DEATH

15655

15650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> | |
| c. LENGTH OF STAY IN 1b <u>5 days</u> | | d. STREET ADDRESS <u>4826 Butterfield Place</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Mac</u> Last <u>Leod</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1967</u> | |
| 5. SEX <u>1-F</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/3/1896</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>-</u> | |
| 14. MOTHER'S MAIDEN NAME <u>-</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u> | |
| 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Helen L. MacLeod - See Item #2.</u> Address <u>-</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro Vascular Insufficiency</u>
DUE TO (b) <u>Thrombosis Left Subclavian Artery</u>
DUE TO (c) <u>Generalized Atherosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> , 19 <u>65</u> , to <u>Nov 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 12</u> 19 <u>67</u> , and that death occurred at <u>4:10 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stanley M. Bialek</u> | | 22b. DATE SIGNED <u>12 Nov 67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Stanley M. Bialek</u> | | 22d. ADDRESS <u>8218 Wisc. Ave. Beth. Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-16-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 20 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 10821 Film 395
12-13-67 ams
15655
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15651

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
c. LENGTH OF STAY IN lb <u>10 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8805 Plymouth St., Apt. 5</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> #5
d. STREET ADDRESS <u>8805 Plymouth St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Grant Mac Minn</u>
First Middle Last | | 4. DATE OF DEATH <u>11 29 1967</u>
Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>08 10-24-07</u>
yrs. |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u> | |
| 10. FATHER'S NAME <u>Unknown</u> | | 11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u> | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> | | 13. SOCIAL SECURITY NO. <u>yes</u> | |
| 14. INFORMANT <u>Florence MacMinn</u> | | 15. ADDRESS <u>8805 Plymouth Street Silver Spring, Md.</u> | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute, left, Coronary occlusion with</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction; Coronary</u>
(c) <u>artery heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Wharton</u> Address <u>Street City or county</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>Dec. 4, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rochester, Massachusetts</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>8434 Georgia Avenue</u>
<u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 5 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

1952

1952

X X X

1952

1952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15652

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | | c. LENGTH OF STAY IN 1b
Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MONTGOMERY GEN. HOSPITAL | | d. STREET ADDRESS
3408 Leisure 15-1
3504 Chiswick Court, World | |
| 3. NAME OF DECEASED
(Type or print)
Gerald Harper Mains | | 4. DATE OF DEATH
Month November Day 30 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/24/93 |
| 9. AGE (In years last birthday)
74 72 yrs. | | IF UNDER 1 YEAR
Months 30 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
chemical engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
plastics | |
| 11. BIRTHPLACE (State or foreign country)
Michigan | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Elmer Mains | | 14. MOTHER'S MAIDEN NAME
Alice Easton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
unknown WWI | | 16. SOCIAL SECURITY NO.
162-05 | |
| 17. INFORMANT
Montgomery General Hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | 22. DATE SIGNED
Dec. 1, 1967 | |
| EXAMINER'S NAME (Type)
Belden R. Reap, M.D. | | DEPUTY MEDICAL EXAMINER
Wheaton | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
1 Dec 67 | 23c. NAME OF CEMETERY OR CREMATORY
Wheaton Wash Union Hosp | 23d. LOCATION (City or Town) (County) (State)
Wash. D.C. |
| 24. FUNERAL DIRECTOR
Frederick Sons Inc | | 25a. REC'D BY REGISTRAR
DEC 4 1967 | |
| ADDRESS
Frederick Sons Inc | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

15658

15653

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Ohio b. COUNTY Hamilton | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
3 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9216 Cedar Way | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
KARL H. MALLUVIUS | | 4. DATE OF DEATH
Month Nov. Day 5 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar. 27, 1905 |
| 9. AGE (In years last birthday) yrs.
62 | | 10. IF UNDER 1 YEAR
Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pipe Fitter | | 10b. KIND OF BUSINESS OR INDUSTRY
Plumbing | |
| 11. BIRTHPLACE (County & State, or foreign country)
Bremen, Germany | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Otto Malluvius | | 14. MOTHER'S MAIDEN NAME
Helena Krezemeier | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Daughter Ursula Davidson | | 18. ADDRESS
9216 Cedar Way Bethesda, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LIVER FAILURE
DUE TO (b) METASTATIC CANCER
DUE TO (c) CANCER OF COLON | | | INTERVAL BETWEEN ONSET AND DEATH
8 mos.
8 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 6 , 19 67 , to 11/5 , 19 67 , that (I) (we) lost saw the deceased alive on 11/3 , 19 67 , and that death occurred at 6:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Herbert A. Moskovitz | | 22b. DATE SIGNED
Nov. 5, 1967 | 22c. PHYSICIAN'S NAME (Type)
HERBERT A. MOSKOVITZ |
| 22d. ADDRESS
916 - 19th St., N. W. Washington, D. C. | | 22e. REC'D BY REGISTRAR
Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
11-7-67 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25. REC'D BY REGISTRAR
NOV 9 1967 | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15654

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u> | | d. STREET ADDRESS <u>5453 Newton St.</u> # <u>7</u> | |
| 3. NAME OF DECEASED (Type or print) <u>George Henry Manning Sr.</u> | | 4. DATE OF DEATH
Month <u>11</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-1-07</u> |
| 9. AGE (In years lost birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sr. sten. atten.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Manning</u> | | 14. MOTHER'S MAIDEN NAME <u>ALICE Franks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>577 10 5963</u> | |
| 17. INFORMANT <u>MRS N. LOUISE MANNING</u> | | Address <u>SAME AS #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u>
DUE TO <u>Coronary Artery Heart Disease</u>
(b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>
DUE TO <u>last.</u>
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u>
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>Nov. 11, 1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | DEPUTY MEDICAL EXAMINER <u>W. W. Chambers</u> (Type or print name and county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11-14-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u> | 23d. LOCATION (City or Town) (County) (State) <u>COLMAR MANOR, MARYLAND</u> |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. RIVERDALE, MD</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of", "in" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>MONT.</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | | | c. LENGTH OF STAY IN MD <u>15 1</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2311 PLYERS Mill Rd.</u> | | | | | | d. STREET ADDRESS <u>2311 PLYERS Mill Rd.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>I.</u> Last <u>MARCHI</u> | | | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>NOV</u> Year <u>1967</u> 19 | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>30 JUNE 1882</u> | | 9. AGE (In years last birthday) <u>85 yrs.</u> | | 10. IF UNDER 1 YEAR (Months) Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRONMENTAL THEATER</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>ITALY - WCCS.</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | | |
| 13. FATHER'S NAME <u>BASILIO MARCHI</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>CELESTE BARSONI</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>579-69-6008A</u> | | | | | |
| 17. INFORMANT <u>JUNIOR C. MARCHI</u> Address <u>1074 Douglass Ave S.E. 55th St.</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | | | |
| 4201 DUE TO (b) <u>Arterio-sclerosis Cardiac disease</u> 10 years | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Emphysema.</u> 3 years | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>R. N. Mangano</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/14/67</u> | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>15 Nov. 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GATE of HEAVEN</u> 23d. LOCATION (City, town or county) (State) <u>SILVER SPRING MD.</u> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC.</u> ADDRESS <u>1400 GORDON AVE. NW</u> 25a. REC'D BY REGISTRAR <u>NOV 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Pennsylvania</u> b. COUNTY <u>Kingston</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>59 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | d. STREET ADDRESS
<u>26 West Bennett Street</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Harold Lewis Mark</u> | | 4. DATE OF DEATH Month Day Year
<u>November 13 1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>13 November 1946</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 9b. KIND OF BUSINESS OR INDUSTRY
<u>--</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>--</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Sidney Mark</u> | | 14. MOTHER'S MAIDEN NAME
<u>Betty Bosch</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>The Medical Records</u>
<u>The Clinical Center, Bethesda, Maryland</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gram-negative septicemia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute perforation of appendix</u>
DUE TO
(c) <u>Acute myelogenous leukemia</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Intracranial hemorrhage</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 days</u>
<u>11 months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
<u>13</u> | |
| 21. I certify that he (this hospital) attended the deceased from <u>September 15 1967</u> , to <u>November 7, 1967</u> , that he (we) last saw the deceased alive on <u>November 13 1967</u> , and that death occurred at <u>5:20M</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Thomas Clancy</u> | | 22b. DATE SIGNED
<u>13 Nov. 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Thomas Clancy, MD</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11/14/1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>W. Pittston Jewish Cem</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>W. Pittston Luzerne Co. Pa</u> | |
| 24. FUNERAL DIRECTOR
<u>Samuel L. Rosenberg</u> | | 25a. REC'D BY REGISTRAR
<u>W. H. Barre</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>William H. Barre</u> | | DATE
<u>NOV 16 1967</u> | |

13322

13321

James Henry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15662

CERTIFICATE OF DEATH

15657

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
c. LENGTH OF STAY IN 1b
10 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | |
| 3. NAME OF DECEASED
(Type or print)
Clarence Ashby Marshall | | 4. DATE OF DEATH
Month November Day 10 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years lost birthday) yrs.
75 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, and in last 12 months)
Retired Flooring | | 10b. KIND OF BUSINESS OR INDUSTRY
Building | 11. BIRTHPLACE (County & State, or foreign country)
Washington D.C. |
| 12. CITIZEN OF WHAT COUNTRY?
America | | 13. FATHER'S NAME
Clarence W. Marshall | |
| 14. MOTHER'S MAIDEN NAME
Sally Golden | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWI | |
| 16. SOCIAL SECURITY NO.
578-20-8715 | | 17. INFORMANT
Blanche Marshall Address 2253 Hannon Street, Q. Hyattsville, Md.
Patient's Chart | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 450.0 Fulminating bilateral pneumonia
DUE TO (b) Post surgery hip nailing; severe extensive
DUE TO (c) Arteriosclerosis; Diabetes Mellitus.
INTERVAL BETWEEN ONSET AND DEATH
8 days
8 days
4-5 yrs | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell in nursing home & fractured hip | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 9-28 19 67
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
Nursing home | 20f. (City or town) (County) (State)
Hyattsville Pr. Geo. Md. |
| 21. I certify that (I) (this hospital) attended the deceased from May, 1961 , to Nov 10, 1967 , that (I) (we) last saw the deceased alive on Nov 9, 1967 , and that death occurred at 5:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Robert B. Irey | | 22b. DATE SIGNED
11-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT B. IREY | | 22d. ADDRESS
11161 New Hampshire Ave, Silver Spring | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Nov. 13, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland |
| 24. FUNERAL DIRECTOR
C. Glen Carter 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
NOV 15 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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3800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|--|---|---|
| 15663 | | | |
| CERTIFICATE OF DEATH | | | |
| 15658 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Arlington</u> | |
| c. LENGTH OF STAY IN lb
<u>96 days</u> | | d. STREET ADDRESS
<u>5011 North 4th Street</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Naval Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>David</u> Middle <u>L.</u> Last <u>MARTIN</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 27, 1908</u> |
| 9. AGE (In years last birthday) yrs.
<u>59</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>U. S. Navy</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Dayd City, Florida</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Jesse Earl Martin</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mildred Blair</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>230-48-9263</u> | |
| 17. INFORMANT
<u>Hospital records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary emboli, massive bilateral</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Carcinoma of the stomach</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____
p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 25</u> , 19 <u>67</u> , to <u>Nov. 29</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 29</u> , 19 <u>67</u> , and that death occurred at <u>8:15 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James E. Davis</u> | | 22b. DATE SIGNED
<u>30 Nov 67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>James E. Davis</u> | | 22d. ADDRESS
<u>Naval Hospital, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>Burial</u> | 23b. DATE THEREOF
<u>12-5-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR
<u>Arlington Funeral Home</u>
<u>3901 North Fairfax Drive, Arlington, Va.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 5 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10000

10000

RECORD OF DEATH

(1000)

10000

10000

10000

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10000

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10000

15659

CERTIFICATE OF DEATH

15664

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Mont.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Pa.</u> b. COUNTY <u>1</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> | |
| c. LENGTH OF STAY IN 1b <u>28 days</u> | | d. STREET ADDRESS <u>2717-S. Walter End</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Storothy Julia Martin</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/2/19</u> |
| 9. AGE (In years last birthday) <u>48</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>15</u> Ooys <u>15</u> Hours <u>15</u> Min. <u>15</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>private</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>private</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Adams</u> | | 14. MOTHER'S MAIDEN NAME <u>Taylor</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>yes</u> | |
| 17. INFORMANT <u>Lewis Owen Martin</u> | | Address <u>Taylor</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u>
DUE TO (b) <u>163x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>163x</u>
DUE TO (c) <u>163x</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>april</u> | 20f. (City or town) (County) (State) <u>Nov 15 1967</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> to <u>Nov 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/5/67</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> p.m., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jay R. Shapiro</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>11-16-67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u> | | 22d. ADDRESS <u>8218 Wisconsin Ave. Avenue, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-19-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fairfield Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Stamford, Conn.</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 17 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

63781

STATE OF TEXAS

1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> 15665 CERTIFICATE OF DEATH 15660 </div> | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Kensington</u>
<u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington Md.</u> | | | | c. LENGTH OF STAY IN 1b
<u>151</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Kensington Gardens San.</u> | | | | | | d. STREET ADDRESS
<u>25 East Wayne Avenue</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Sophia S. Maskell</u> | | | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>8</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5-2-81</u> | | 9. AGE (In years last birthday)
<u>86</u> yrs. | | IF UNDER 1 YEAR
Months <u>8</u> Days <u>19</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Halifax, Nova Scotia</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Sutherland</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Matheson</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>yes</u> | | 17. INFORMANT
<u>Charles Maskell</u> <u>25 East Wayne Avenue Silver Spring, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Decomposition</u>
<u>4500</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 1/2 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebral thrombosis & stroke</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u>
p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8 Nov 1967</u> , 19 <u>65</u> , to <u>8 Nov 1967</u> , that (I) (we) last saw the deceased alive on <u>6 Nov 1967</u> , and that death occurred <u>at 11:30 pm</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>William D. And</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>11/8/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William D. And</u> | | | | | | 22d. ADDRESS
<u>9006 Colesville, Rd. Silver Spring, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-burial</u> | | 23b. DATE THEREOF
<u>Nov. 11, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Milton Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Boston, Massachusetts</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Clark E. Wisor</u> <u>8434 Georgia Avenue</u>
<u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>NOV 13 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20530

ATTENTION: LAND ACQUISITION SECTION

WASHINGTON, D. C. 20530

TELEPHONE: 205-3000

TELETYPE: 205-3000

FAX: 205-3000

MAILING ADDRESS: 205-3000

WASHINGTON, D. C. 20530

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

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UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20530

ATTENTION: LAND ACQUISITION SECTION

WASHINGTON, D. C. 20530

TELEPHONE: 205-3000

TELETYPE: 205-3000

FAX: 205-3000

MAILING ADDRESS: 205-3000

WASHINGTON, D. C. 20530

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

15666

CERTIFICATE OF DEATH

15661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Nelson</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN lb
<u>226 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Roseland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u>
<u>The Clinical Center, Bethesda, Maryland</u> | | | | d. STREET ADDRESS
<u>Route 1, Box 13B</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Inetta</u> Middle <u>(None)</u> Last <u>Mason</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>2</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>21 December 1933</u> | 9. AGE (In years last birthday)
<u>33</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housekeeping</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Domestic</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Andrew Mason</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Smith</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unavailable</u> | | 17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland 20014</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>205X</u> IMMEDIATE CAUSE (a) <u>Mycosis Fungoides</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u>
(c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (x) (this hospital) attended the deceased from <u>March 21</u> , 19 <u>67</u> , to <u>November 2</u> , 19 <u>67</u> , that (x) (we) last saw the deceased alive on <u>Nov. 2</u> , 19 <u>67</u> , and that death occurred at <u>12:35 M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Arthur N. Kales</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> AM STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2 November 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Arthur N. Kales, M.D.</u> | | | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>11-4-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>HARMONY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>LANDOVER, Md</u> | |
| 24. FUNERAL DIRECTOR
<u>FRAZIER'S - WASHINGTON, D.C.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

10081

10081

10081

10081

CERTIFICATE OF DEATH

15662

15662

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u>
c. LENGTH OF STAY IN 1b
<u>15-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1513 Woodman Avenue</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u>
d. STREET ADDRESS
<u>1513 Woodman Avenue</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>JOHN BRADBURN MATHEWS</u> | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-24-1923</u> |
| 9. AGE (In years last birthday)
<u>44</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Department of Defense</u> | | 11b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Govt.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>South Dakota</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Oscar Mathews</u> | | 14. MOTHER'S MAIDEN NAME
<u>Adelaide Bradburn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes 2-1943 to 10-1943</u> | | 16. SOCIAL SECURITY NO.
<u>579-26-1847</u> | |
| 17. INFORMANT
<u>Georgia Ann Mathews-See Item No. 2</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>163X</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>April 1967</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Nov 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 9</u> , 19 <u>67</u> , and that death occurred at <u>5 A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Blaine H. Zeig</u> | | 22b. DATE SIGNED
<u>Nov 10, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>BLAINE H. ZEIG</u> | | 22d. ADDRESS
<u>2641 Colver Road Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | 23b. DATE THEREOF
<u>11-14-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Nat'l. Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc.</u>
<u>5130 Wisc. Ave. N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 15 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15668

CERTIFICATE OF DEATH

15663

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>211 Cedar Avenue</u> | | d. STREET ADDRESS
<u>211 Cedar Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Ella G. McAtee</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 26, 1885</u> |
| 9. AGE (In years lost birthday) yrs. <u>82</u> | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William McAtee</u> | | 14. MOTHER'S MAIDEN NAME
<u>Virginia Purdum</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213 50 5916</u> | |
| 17. INFORMANT
<u>Mrs. Evelyn Selby- sister-</u> | | Address <u>same item #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>2865</u> IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u>
DUE TO (b) <u>Mal Nutrition</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>one month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> , 19 <u>67</u> , to <u>11-15</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>12:20</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>L. I. Leal</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>L. I. Leal</u> | | 22d. ADDRESS
<u>Medical Center-Gaithersburg, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF
<u>11/18/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Darnestown</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Darnestown, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 17 1967</u> | |
| ADDRESS <u>Rockville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15663

CERTIFICATE OF DEATH

15664

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|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1 | |
| c. LENGTH OF STAY IN lb <u>DoA</u> | | d. STREET ADDRESS <u>7017 Wagstaffe</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David O. McDonough</u> First Middle Last | | 4. DATE OF DEATH <u>Nov 14 1967</u> Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/31/67</u> 9. AGE (In years last birthday) <u>7ms</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Mont</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Patrick Joseph McDonough</u> | | 14. MOTHER'S MAIDEN NAME <u>Nancy Oliver</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Patrick J. McDonough - Item # 2</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Disease</u>
DUE TO (b) <u>(Common truncus, trilobular)</u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/31/67</u> , 19 <u>67</u> , to <u>11/14/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/13/67</u> , 19 <u>67</u> , and that death occurred at <u></u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Vincent J. O'Donnell</u> | | 22b. DATE SIGNED <u>11/15/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Vincent J. O'Donnell</u> | | 22d. ADDRESS <u>5415 W. Cedar Ln Bethesda</u> | |
| 23a. BURIAL, CREMATION, REMAINS SPECIFY <u>BURIAL</u> | 23b. DATE THEREOF <u>11/16/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler, Rockville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 17 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15670

15665

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>Maryland</u> b. COUNTY
<u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN lb
<u>4 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | d. STREET ADDRESS
<u>100 Lucas Lane</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Henry Thomas Mc Gaughan</u> | | 4. DATE OF DEATH
Month Day Year
<u>Nov 24 1967</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-29-81</u> |
| 9. AGE (In years last birthday)
<u>86</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>24</u> <u>19</u> <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>conductor (civil)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>self-employed</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Bay City, Michigan</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Alexander Stanley Mc Gaughan</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ida Little</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No.</u> | | 16. SOCIAL SECURITY NO.
<u>366-34-7322</u> | |
| 17. INFORMANT <u>-son</u>
<u>A. Stanley Mc Gaughan - Bethesda, Md.</u> | | Address <u>100 Lucas Lane</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1 Coronary Atherosclerosis</u>
DUE TO <u>2 Cancer of Bladder</u>
(b) <u>3 Cancer of Lung</u>
DUE TO <u>4 Senility</u>
(c) <u>5</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u>
"
" |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>67</u> , to <u>11/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/23</u> , 19 <u>67</u> , and that death occurred at <u>12:15 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. T. Joyce</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. T. Joyce</u> | | 22d. ADDRESS
<u>4977 Battery Lane Bethesda Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | 23b. DATE THEREOF
<u>11/27/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 4 1967</u> | |
| ADDRESS <u>Wash.D.C.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| <u>5130 Wisconsin Ave.N.W.</u> | | DATE | |

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OFFICE OF THE DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>1730 H. Street N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ALBERT I MCGEECH</u> | | 4. DATE OF DEATH <u>Nov 28 19 67</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-7-1901</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst-comm. government</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>England</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Mc Geagh</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO. <u>065-405-1853</u> | |
| 17. INFORMANT <u>George Mc Geagh</u> | | Address <u>Brooklyn</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Recent & Remote</u>
DUE TO (b) <u>Coronary Arteriosclerosis</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John B. Ball</u> M.D. | | 22. DATE SIGNED <u>11/28/67</u> | |
| EXAMINER'S NAME (Type) <u> </u> | | Address (Street, city, town, or county) <u> </u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/1/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN, NEW YORK</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR <u> </u> | |
| 4308 SUTLAND ROAD, SUTLAND, MARYLAND | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>DEC 1 1967</u> | | | |

15538

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Special Agent in Charge, Federal Bureau of Investigation

Washington, D. C.

Very truly yours,

J. Edgar Hoover

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15672

CERTIFICATE OF DEATH

15667

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> | | d. STREET ADDRESS <u>5826 Vandergrift Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mrs Cora Rebecca McGill</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 29, 1893</u> 74 yrs. |
| 9. AGE (In years lost birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Ret. Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Henry King</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Martha Minnick</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-26-5526A</u> | |
| 17. INFORMANT <u>Mrs. Donald L. Loy Rockville, Maryland</u> | | 18. RESIDENCE <u>5826 Vandergrift Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO <u>Arteriosclerotic heart disease</u>
DUE TO <u>Diabetes mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Apr</u> , 19 <u>67</u> to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>21 Nov</u> 19 <u>67</u> , and that death occurred at <u>1:32 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Paul D. Loy</u> | | 22b. DATE SIGNED <u>21 Nov 67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>?</u> | | 22d. ADDRESS <u>?</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-25-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u> | | 25a. REC'D BY REGISTRAR <u>NOV 27 1967</u> | |
| ADDRESS <u>Frederick, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|--|--|--|--|---|--|---|--|
| 15673 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 15668 | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | c. LENGTH OF STAY IN lb
7 Months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Carroll Hall Nursing Home | | | | d. STREET ADDRESS
7518 Old Chester Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) RUTH | | | | 4. DATE OF DEATH
Month Nov Day 10 Year 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 13, 1876 | |
| 9. AGE (In years last birthday) yrs. 91 | | IF UNDER 1 YEAR
Months 10 Days 19 Hours 67 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SCHOOL TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
578-62-3277J1 | | 17. INFORMANT
Edward Mitchell | | Address
Washington, D. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Bronchitis
4500 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis
DUE TO (c) with Senility | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 2, 1950 , to Nov 10, 1967 , that (I) (we) last saw the deceased alive on Nov 1, 1967 , and that death occurred at 10:30 A.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Thomas S. Sappington | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
11/10/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Thomas S. Sappington, M. D. | | | | 22d. ADDRESS
2233 Wisconsin ave., N.W., D. C. 20007 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
10-11-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | ADDRESS
Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
NOV 14 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 396
12-20-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15669

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK
c. LENGTH OF STAY IN 1b
WASHINGTON SAN. & HOSP. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING
d. STREET ADDRESS
1100 GADSDEN AVE. | |
| 3. NAME OF DECEASED
(Type or print)
WILLIAM HAROLD MCKAY | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 17 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 18, 1922
9. AGE (In years last birthday)
45 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ADMINISTRATIVE CLERK JOHN HOPKINS | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
ANDREW MCKAY | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
YES WW2 Army | | 14. MOTHER'S MAIDEN NAME
EDITH BARNES | |
| 16. SOCIAL SECURITY NO.
216-16-5136 | | 17. INFORMANT
MRS. BEVERLY M. MCKAY Address: (Same as #2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1
DUE TO Acute coronary insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery heart disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Essential hypertension | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | 22. DATE SIGNED
Nov. 18, 1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | DEPUTY MEDICAL EXAMINER
Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Nov 21-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR
Arthur Waters | | 25a. REC'D BY REGISTRAR
NOV 21 1967 | |
| ADDRESS
254 S. ... | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|-------------------------|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15675 CERTIFICATE OF DEATH 15670 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Washington, D.C. b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47-3 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Kensington Gardens Sanitarium | | | | | d. STREET ADDRESS
4899 Potomac Ave., N.W. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) ARCHIBALD First V Middle McKEE Last | | | | | 4. DATE OF DEATH
Nov. 20 19 67 Month Day Year | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 6, 1897 | | 9. AGE (In years last birthday)
70 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Archibald V. McKee | | | | | 14. MOTHER'S MAIDEN NAME
Anna Marie Hale | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | | | 16. SOCIAL SECURITY NO.
579-16-5256 | | 17. INFORMANT
Mrs. Helen Y. McKee (wife) Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion
DUE TO Coronary arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 1 hour
(c) Sev. yrs | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Left side hemiplegia | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1967 to Nov. 20, 1967 that (I) (we) last saw the deceased alive on Nov. 10, 1967 and that death occurred at 7:20 PM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Lynwood Heiges, M.D. | | | | 22b. DATE SIGNED
Nov. 20, 1967 | | 22c. PHYSICIAN'S NAME (Type)
LYNWOOD HEIGES, M.D., F.A.C.A. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11-24-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington, D.C. 20012 Riverside Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Oneonta New York | | |
| 24. FUNERAL DIRECTOR
Ives Funeral Home, Inc., 2847 Wilson Blvd. | | | | 25a. REC'D BY REGISTRAR
Nov 24 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (1)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15675

CERTIFICATE OF DEATH

15671

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u>
c. LENGTH OF STAY IN b
<u>10 years</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
<u>Washington, DC</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington, DC</u>
d. STREET ADDRESS
<u>1311 Juniper St., N.W.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CLARA</u> Middle <u>M. McLAUGHLIN</u> Last
4. DATE OF DEATH
Month <u>Nov.</u> Day <u>25</u> Year <u>1967</u> | | 5. SEX
<u>Female</u>
6. COLOR OR RACE
<u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
<u>June 9, 1878</u>
9. AGE (In years last birthday)
<u>89</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u>
11. BIRTHPLACE (County & State, or foreign country)
<u>Windsor, Ohio</u>
12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>William Slawkey</u>
14. MOTHER'S MAIDEN NAME
<u>Nancy J. Berous</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u>
16. SOCIAL SECURITY NO.
<u>577-07-2877</u>
17. INFORMANT
<u>Divian Mac Murray</u> Address <u>1311 Juniper St., N.W. Washington, D.C.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY THROMBOSIS</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>SENILITY</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 3, 1957</u> , to <u>Nov. 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25, 1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Henry London</u>
22c. PHYSICIAN'S NAME (Type)
<u>Henry London</u> | | 22b. DATE SIGNED
<u>11/25/67</u>
22d. ADDRESS
<u>3206 Narrows Dr. Chevy Chase, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u>
23b. DATE THEREOF
<u>Nov. 30, 1967</u>
23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u>
23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Maryland</u> | | 24. FUNERAL DIRECTOR
<u>C. Glen Carter</u> ADDRESS
<u>8434 Georgia Avenue</u>
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>
25a. REC'D BY REGISTRAR
DATE <u>DEC 1 1967</u>
25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | | | |
| c. LENGTH OF STAY IN 1b <u>3 weeks</u> | | | | d. STREET ADDRESS <u>6709 East Avenue</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>John Owen McMurrough</u> | | | | 4. DATE OF DEATH <u>November 12</u> 19 <u>67</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Caus.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/13/1886</u> | |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-coal miner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COAL MINE</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Owen McMurrough</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sullivan</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>NONE</u> | | | | 16. SOCIAL SECURITY NO. <u>178-07-1781</u> | | 17. INFORMANT <u>Nursing Home Records</u> Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>201X</u> IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>
DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> , 19 <u>67</u> , to <u>11/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Walter E. Goetz</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>11/12/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOETZ MD</u> | | | | 22d. ADDRESS <u>2309 Shorefield Rd., Wheaton, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>Nov. 15/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. VINCENT DE PAUL</u> | | 23d. LOCATION (City or town) (County) (State) <u>PUNBAR TOWNSHIP - FARMER CO. PA.</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co. WASHINGTON, D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>SC</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>3601 Wisconsin Ave NW</u> <u>47-3</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Augustus F. McNaair</u> First Middle Last | | 4. DATE OF DEATH <u>Nov 14 1967</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-18-1886</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u> | | 11. BIRTHPLACE (State or foreign country) <u>Warsaw - New York</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Eben O. McNaair</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Laura Snow</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Navy</u> | |
| 16. SOCIAL SECURITY NO. <u>578-52-6477A</u> | | 17. INFORMANT <u>Wife - Maurine McNaair</u> Address <u>Same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lymphocytic Leukemia -</u>
2040
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL EXAMINER'S SIGNATURE <u>John W. Ball</u> M.D. | | 22. DATE SIGNED <u>11/14/67</u> | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-17-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> | | 25. REC'D BY REGISTRAR <u>Nov 20 1967</u> | |
| 25a. ADDRESS <u>5130 Wash. D.C. Ave. N.W.</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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James M. McNamee

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15673 CERTIFICATE OF DEATH 15674

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>55 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>720 University Blvd. East</u> | | d. STREET ADDRESS <u>720 University Blvd. East</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Romaine Tindall Meeds</u> | | 4. DATE OF DEATH <u>Nov 26 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 17 1877</u> |
| 9. AGE (In years last birthday) <u>89 yrs.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTH PLACE (County & State, or foreign country) <u>Independence, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> | |
| 13. FATHER'S NAME <u>Robert B. Tindall</u> | | 14. MOTHER'S MAIDEN NAME <u>Henrietta Eccles</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-14-1527</u> | |
| 17. INFORMANT <u>Romaine Warren</u> | | Address <u>211 Williamsburg Drive Silver Spring, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis, Cardiac Failure</u>
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) <u>Cerebral Thromboses multiple small</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hip, right, old (1962)</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. _____ 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>62</u> , to <u>Nov 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 24</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>George L. Ball</u> | | 22b. DATE SIGNED <u>Nov 26, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u> | | 22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 28, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 28 1967</u> | |
| ADDRESS <u>134 D. Thomas</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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21-2-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| 15680 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15675 | | | |
|---|--|---------------------------|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>MONTG.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING - MD 151</u> | | | | | |
| c. LENGTH OF STAY IN lb <u>3 mo. & 1 day</u> | | | | | | d. STREET ADDRESS <u>1605 DALE DRIVE</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp.</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM F MEHLING</u> | | | | | | 4. DATE OF DEATH <u>NOV. 4 1967</u> | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-9-17</u> | | 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR 19 <u>67</u>
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u> | | | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> | | | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | | | | |
| 13. FATHER'S NAME <u>JOHN MEHLING</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>LORETTA Judge</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u> | | | | | | 16. SOCIAL SECURITY NO. <u>217-07-1473</u> | | 17. INFORMANT <u>Catherine A. Mehling</u> Address <u>1605 Dale Dr. Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, generalized</u>
DUE TO (b) <u>Bronchogenic carcinoma, right lung</u>
DUE TO (c) <u>1621</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year 18 months</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-3</u> , 1967, to <u>11-4</u> , 1967, that (I) (we) last saw the deceased alive on <u>11-4</u> 1967, and that death occurred at <u>450 P.M.</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Eino Magi</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-5-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u> | | | | | | 22d. ADDRESS <u>831 Univ. Blvd. E. Silver Spring, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>Nov. 8 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u> | |
| 23e. FUNERAL DIRECTOR <u>Glen Carter</u> | | | | 23f. ADDRESS <u>8434 Georgia Ave.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 10 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| 23g. FUNERAL HOME <u>Warner E. Humphrey, Inc.</u> | | | | 23h. ADDRESS <u>Rockville, Md. S.S.</u> | | | | | | | |

STATE OF TEXAS

County of _____

Know all men by these presents, that _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ in hand paid by _____ the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

TO HAVE AND TO HOLD unto the said _____ heirs and assigns forever.

And the said _____ do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of _____ State of Texas.

Witness my hand and seal of office this _____ day of _____ 1933.

County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15681

15676

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>13803 LOREL LANE</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Erin Elisabeth Merrick</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>19</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>November 14, 1967</u> |
| 9. AGE (In years last birthday) <u>4</u> yrs. | | IF UNDER 1 YEAR
Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>James Joseph Merrick</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sherrill Jean Varley</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
<u>Father</u> | | Address
<u>as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
<u>7735</u> IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u>
DUE TO <u>ic. neonatal osteolysis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Immaturity</u>
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 1/2 days</u>
<u>4 1/3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 14</u> , 19 <u>67</u> , to <u>NOV. 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>NOV. 18</u> , 19 <u>67</u> , and that death occurred at <u>6:10 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Edward J. Feroli</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>EDWARD J. FEROLI</u> | | 22b. DATE SIGNED
<u>11/19/67</u> | |
| 22d. ADDRESS
<u>11125 Rockville Pike, Rockville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11/21/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler</u> | | ADDRESS
<u>1331 Rockville Pike, Rockville, Maryland</u> | |
| 25a. REC'D BY REGISTRAR
<u>DATE NOV 21 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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STATE OF KANSAS

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15682

15677

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban</u> | | | | d. STREET ADDRESS
<u>429 E. Wisconsin Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Harry Carter Merry</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept 20 - 1884</u> | 9. AGE (In years last birthday) yrs. <u>83</u> | IF UNDER 1 YEAR
Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Ephraim R. Merry</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lizzie Carter</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Earl Groun - Niece - Hogerstown</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary thrombosis, old and recent</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Coronary arteriosclerosis, severe</u>
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>years.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>John W. Ball</u> | | EXAMINER'S NAME (Type)
<u>John W. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
<u>11/13/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>X</u> | | 23b. DATE THEREOF
<u>11-16-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Lutheran</u> | | 23d. LOCATION (City or Town) | (County) | (State)
<u>Levinsonville Va</u> |
| 24. FUNERAL DIRECTOR
<u>Ernest C. Gartner</u> | | | | ADDRESS
<u>Gaithersburg</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 16 1967</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1893

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My dear Mary

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My dear Mary

My dear Mary

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a,b,c & d prior, taken from birth cert. | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|--|--|---|--|
| 15683 | | | | | | 15678 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u> ✓ | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hinsdale</u> | | | | 51.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hosp.</u> | | | | | | d. STREET ADDRESS
<u>821 Phillippa St.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Charles</u> First <u>A.</u> Middle <u>Middaugh</u> Last | | | | | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>22</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11/20/67</u> | | 9. AGE (In years last birthday) yrs. <u>2</u> | | IF UNDER 1 YEAR
Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Ind</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>James William Russell</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>PATRICIA R.</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Hospital Records</u> | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity, Respiratory distress syndrome</u>
7735
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Premature Birth (1900gm) neonatal death</u>
DUE TO
(c) <u>Respiratory distress syndrome (clinical)</u>
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>67</u> to <u>11-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>67</u> , and that death occurred at <u>4P</u> M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Albert J. Modlin</u> | | | | | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Albert J. Modlin, M.D.</u> | | | | | | 22d. ADDRESS
<u>704 Gorman Ave., Laurel, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>12/4/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>
<u>Rockville, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 6 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

7-242803

1888

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James William Russell

James William Russell

Albert J. Odum, M.D.

Dr. Berman

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15684

CERTIFICATE OF DEATH

15679

| | | | |
|--|---------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY Fairfax | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annandale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
The Clinical Center, Bethesda, Maryland | | d. STREET ADDRESS
8142 Briar Creek Drive | |
| 3. NAME OF DECEASED
(Type or print)
First Charles Middle Lewis Last Mikelson | | 4. DATE OF DEATH
Month November Day 9 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
19 November 1929 |
| 9. AGE (In years last birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pilot | | 10b. KIND OF BUSINESS OR INDUSTRY
Commercial Airlines Nebraska | |
| 11. BIRTHPLACE (County & State, or foreign country)
Nebraska | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Gunder Mikelson | | 14. MOTHER'S MAIDEN NAME
Opel Austin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes 1947 | | 16. SOCIAL SECURITY NO.
521-30-3541 | |
| 17. INFORMANT
The Medical Records | | The Clinical Center, Bethesda, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) E coli septicemia
2043 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
1 week
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Acute renal failure | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from October 30, 19 67, to November 9, 19 67, that (we) last saw the deceased alive on November 9, 19 67, and that death occurred at 5:20M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Richard A. Creech | | 22b. DATE SIGNED 1967
10 November | |
| 22c. PHYSICIAN'S NAME (Type)
Richard H. Creech, MD | | 22d. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11/13/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Falls Church; Fairfax; Va. | |
| 24. FUNERAL DIRECTOR
Everly-Wheatley Funeral Home | | 25a. REC'D BY REGISTRAR
DATE NOV 14 1967 | |
| ADDRESS
Alexandria, Va. | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

15378

15378

OFFICE OF DEATH

The following is a list of the names of the deceased persons who have been buried in the cemetery of the City of New York, during the month of January, 1901.

1. *[Faint, illegible text]*

2. *[Faint, illegible text]*

3. *[Faint, illegible text]*

4. *[Faint, illegible text]*

5. *[Faint, illegible text]*

6. *[Faint, illegible text]*

7. *[Faint, illegible text]*

8. *[Faint, illegible text]*

9. *[Faint, illegible text]*

10. *[Faint, illegible text]*

11. *[Faint, illegible text]*

12. *[Faint, illegible text]*

13. *[Faint, illegible text]*

14. *[Faint, illegible text]*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15680

FOR STATE
HEALTH DEPT.

15685

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>F.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>151</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>9318-Crawford Lane</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Richard C. Miller</u> | | 4. DATE OF DEATH <u>Nov. 7</u> 19 <u>67</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 5, 1953</u> |
| 9. AGE (In years last birthday) <u>14</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Tex.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Harriet Lyon</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>father</u> Address <u>Same as Item 2.</u> | | 17. INFORMANT <u>James E. Miller</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
DUE TO <u>9360</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>due to hanging</u>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>13 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>accidentally hung him self when playing with a rope</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>Nov 7 1967</u> <u>4:45 p.m.</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Rockville Montgomery Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>11/8/67</u> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-13-67 Burial</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gettysburg Natl Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Gettysburg, Penna.</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 13 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

15681

| | | | | | | | |
|--|---------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>AN</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | | c. LENGTH OF STAY IN 1b
<u>81 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Naval Hospital</u> | | | | d. STREET ADDRESS
<u>Box 323 Route 3</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Shirley S. MILLER</u> | | | | 4. DATE OF DEATH Month Day Year
<u>November 24 19 67</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>February 21, 1907</u> | | 9. AGE (In years last birthday)
<u>60</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>United States Navy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>ADM Ret.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Eustis, Florida</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Irvin MILLER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth LaRUE</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>1927-1956-57</u> | | 17. INFORMANT Address
<u>Wife Box 323 Route 3 Annapolis, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>14 September 19 67</u> , to <u>24 Nov</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>24 November 19 67</u> , and that death occurred at <u>755A M</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>R.B. Moquin</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>24 Nov 67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Cdr R. B. Moquin, USN</u> | | | | 22d. ADDRESS
<u>Naval Hospital, Bethesda, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, <u>CREMATION</u>
(Specify) | | 23b. DATE THEREOF
<u>11/25/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>FORT LINCOLN CREM.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>PRINCE GEO. CO. MD</u> | |
| 24. FUNERAL DIRECTOR
<u>John M. Taylor</u> | | | | 25a. REC'D BY REGISTRAR
<u>NOV 28 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John M. Taylor</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15783

15783

UNITED STATES

DEPARTMENT OF AGRICULTURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18, 21 film #395 MARYLAND STATE DEPARTMENT OF HEALTH
12-6-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #7 & 9 Film G395 11/21/67 kk
15687 Item 15 Film G395 11/21/67 kk MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15682

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u> | | | | d. STREET ADDRESS <u>4415 Garrett Pk. Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Victor C. Miller</u> | | | | 4. DATE OF DEATH
Month <u>11</u> Day <u>11</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>58 Approx.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>Kirby Lee Miller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nannie E. Clark</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No USN World War II</u> | | | | 16. SOCIAL SECURITY NO. <u>225-09-8628</u> | | 17. INFORMANT
Address <u>St. Leonard, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u>
DUE TO (b) <u>0021</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Read</u> M.D. | | | | 22. DATE SIGNED <u>Nov. 12, 1967</u> | | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Shackburg, Virginia</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 13, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>McCormick Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Middletown, Frederick, Virginia</u> | |
| 24. FUNERAL DIRECTOR'S NAME (Type) <u>Shackburg Funeral Home</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| Rep. By <u>J. Arthur Shivers</u> By <u>Dr. J. Arthur Shivers</u> | | | | DATE <u>NOV 17 1967</u> | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15682

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15683

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chevy Chase</u> | | c. LENGTH OF STAY IN 1b
<u>15</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>4701 Willard Avenue</u> | | d. STREET ADDRESS
<u>4701 Willard Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>LILLIE L. MOLLER</u> | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 10, 1877</u> |
| 9. AGE (In years last birthday)
<u>90</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles E. Lusby</u> | | 14. MOTHER'S MAIDEN NAME
<u>Harriet Fister</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-54-9300</u> | |
| 17. INFORMANT
<u>Mrs. Mary L. Pumphrey, Dtr., Same as #2</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4500</u> IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial -</u>
DUE TO (b) <u>Arterio Sclerosis - Generalized -</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Sat down. head caused fracture of Rt hip</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>pm</u> <u>Oct 2</u> 19 <u>67</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 20f. (City or town) (County) (State)
<u>Bethesda Montgomery Md</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John B. Ball</u> M.D. | | 22. DATE SIGNED
<u>Nov 18, 1967</u> | |
| EXAMINER'S NAME (Type)
<u>JOHN G. BALL</u> | | Address (Street, city, town, or county)
<u>Suitland, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>11/21/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc., Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 24 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. LENGTH OF STAY IN 1b <u>1 1/2 hour</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General</u> | | d. STREET ADDRESS <u>Rt. #1, Box 183</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Boy Monroe</u> | | 4. DATE OF DEATH <u>November 11 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-11-67</u> |
| 9. AGE (In years last birthday) yrs. <u>11</u> | | 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Olney, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Donald B. Monroe</u> | | 14. MOTHER'S MAIDEN NAME <u>Doris Ann MC Bride</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u> </u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>750 X</u> IMMEDIATE CAUSE (a) <u>Anencephalic monster</u>
DUE TO (b) <u> </u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u> </u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>67</u> , to <u>11/11</u> , 19 <u>67</u> , that (I) <u>was</u> lost saw the deceased alive on <u>11/11</u> 19 <u>67</u> , and that death occurred at <u>4:00 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James P. Kerr</u> | | 22b. DATES SIGNED <u>11/11/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES P. KERR</u> | | 22d. ADDRESS <u>Damascus, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-12-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LAYTONSVILLE</u> | 23d. LOCATION (City or Town) (County) (State) <u>LAYTONSVILLE Mont. MD.</u> |
| 24. FUNERAL DIRECTOR <u>Francis J. Barber</u> | | 25a. REC'D BY REGISTRAR <u> </u> | |
| ADDRESS <u>Laytonsville Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>NOV 14 1967</u> | | | |

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|--|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 15685 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
D.C.
b. COUNTY
Washington | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hospital | | | | | | d. STREET ADDRESS
4001 Linnian Avenue, N.W. | | | | | |
| 3. NAME OF DECEASED
(Type or print)
EDGAR NMI MORRIS | | | | | | 4. DATE OF DEATH
Month Nov. Day 26 Year 19 67 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 23, 1888 | | 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 Year
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Executive | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Westinghouse | | 11. BIRTHPLACE (County & State, or foreign country)
South Carolina | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Aaron M. Morris | | | | | | 14. MOTHER'S MAIDEN NAME
Inez Mauldin | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Mary F. Morris, Wife, Same as #2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Cardiac Arrest - myocardial infarction
DUE TO (b) Coronary atherosclerosis 11 years
DUE TO (c) 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from NOV 15, 1965 to NOV 25, 1967 that (I) (we) lost saw the deceased alive on NOV 1, 1967 , and that death occurred at 11:00 M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
G. Lawn Thompson | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
11/26/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
G. Lawn Thompson | | | | | | 22d. ADDRESS
4936 Rodman St., NW, Washington, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11/28/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR
Jos. Gawler's Sons, 5130 Wis. Ave, Wash., D.C. | | | | | | 25a. REC'D BY REGISTRAR
DEC 4 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15691

CERTIFICATE OF DEATH

15686

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Springs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON</u> | |
| c. LENGTH OF STAY IN 1b
<u>Year-5 Mos-11 Days</u> | | d. STREET ADDRESS
<u>616 QUINTANA Pl. N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Fairland Nursing Home-</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Lawrence Benjamin Muzzy</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. B. DATE OF BIRTH
<u>November 2, 1878</u> |
| 9. AGE (In years lost birthday)
<u>89</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>STATISTICIAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>DEPT LABOR</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>WASHINGTON DC.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>DR. ARTHUR MILLS MUZZY</u> | | 14. MOTHER'S MAIDEN NAME
<u>ROSE MAY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>578-44-7310A</u> | |
| 17. INFORMANT
<u>ROBERT L. MUZZY</u> | | Address <u>THREMA PARK, MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>P R O N C H O P N E U M O N I A</u>
DUE TO <u>491X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Nov 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 14</u> 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Boris Rarkin</u> | | 22b. DATE SIGNED
<u>11/14/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>BORIS RARKIN</u> | | 22d. ADDRESS
<u>1019 Union Blvd SE, S.W. Georgia</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>17 Nov. 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>GLENWOOD CEMETERY</u> | 23d. LOCATION (City or Town) (County) (State)
<u>WASHINGTON DC.</u> |
| 24. FUNERAL DIRECTOR
<u>RINALDI FUNERAL HOME, INC</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 17 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>O'Charles Judge</u> | | | |

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